View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by KnowledgeBank at OSU

Kicking the Habit: The Opioid Crisis, America's Addiction to Punitive Prohibition, and the Promise of Free Heroin

JOSH BOWERS† & DANIEL ABRAHAMSON‡

There is no single cause of America's opioid crisis. But unethical physicians and unscrupulous prescription practices undoubtedly have contributed. The federal government has responded predictably: criminally prosecuting doctors who prescribe opioids to the drug dependent. The approach may seem sensible, but it as wrongheaded as our century-old drug war. Indeed, it is part-and-parcel of that misguided struggle. Law enforcement's recent push for punishment might succeed in limiting opioid prescriptions, but only at the cost of driving drug dependent individuals into more dangerous criminal markets, away from narcotics of reliable quality and toward adulterated street heroin and fentanyl. For individuals addicted to opioids or suffering from chronic pain, a criminal drug war has never been a prescription for improving wellness. Indeed, part of the problem is our very obsession with the pejorative notion of "getting clean." It is bad enough to conceive of the drug user as "dirty." It is much worse for a state to monomaniacally pursue an abstinence-based policy model. This dominant model is grounded in the cruel logic of punitive prohibition. It depends not upon healing but upon puritanical blame and shame, isolation and othering, prosecution and penalty. The better model is "harm reduction," grounded in connection and care, reason and rights, human dignity and worth.

The evidence abounds. International and historical public health efforts have demonstrated, for instance, that one of the best ways to confront epidemic drug use is "addiction maintenance"—that is, establishing medically supervised clinics to provide pharmaceutical-grade narcotics (often free of charge) in amounts calibrated to maintain the social and physical wellbeing of the drug dependent. In this essay, we survey these international and historical efforts. We look to our own sometimes-better, sometimes-worse past. We examine the racist roots of the modern American drug war. We describe contemporary reforms, within and beyond the opioid crisis. We explain how meaningful change is likeliest to occur: from the ground up, as a product of underground experimentalism, initiated by and within the most-affected communities. And we offer our own public health prescription: a set of pragmatic harm reduction responses to punitive prohibition and its inhumane, counterproductive, and often deadly effects.

† Professor of Law, University of Virginia School of Law. Many thanks to Rebecca Rubin for her exceptional research assistance.

‡ Founder, Office of Legal Affairs of the Drug Policy Alliance.

TABLE OF CONTENTS

I. INTRODUCTION

In a typical war, strategies change with time. Pragmatic planners abandon goals that prove unattainable or that become undesirable. For a century, this country has fought a criminal war on drugs.[1] Some battle lines have changed, of course. The state has diverted manpower—sometimes back and forth—from opium to heroin, to "reefer madness," to hallucinogens, to powder and crack cocaine, to prescription and nonprescription opioids.[2] Likewise, police, prosecutors, and politicians have supplemented conventional weaponry, like the Harrison Narcotics Act, with more powerful hardware, like the Controlled Substances Act and state law corollaries.[3] Other battle lines have remained constant. For instance, law enforcement has kept its sights trained throughout on black, brown, and poor neighborhoods.[4]

More to the point, the goal of the drug war—*punitive prohibition*—has never shifted. With the exceptions of alcohol, tobacco, and, to a narrow extent, marijuana, recreational drugs are still forbidden, and users are still blamed, shamed, and caged.[5] But, less obviously, the state consistently has prohibited much more. It has obstructed and even prosecuted criminally the activists and medical professionals who would help problematic drug users through

[1] *See generally A Brief History of the Drug War*, DRUG POL'Y ALLIANCE, http://www.drugpolicy.org/issues/brief-history-drug-war [https://perma.cc/J5Q9-YKAL].

[2] *See id.*; *infra* note 35 and accompanying text (discussing historical and contemporary policy and enforcement approaches); *cf.* REEFER MADNESS (George A. Hirliman Productions 1936).

[3] *Infra* note 36 and accompanying text (dating modern drug war to 1914 passage of Harrison Narcotics Tax Act); *The Controlled Substances Act*, U.S. DRUG ENFORCEMENT ADMIN., https://www.dea.gov/controlled-substances-act [https://perma.cc/XG4X-DN7B].

[4] *See infra* note 35 and accompanying text.

[5] *See generally infra* note 106 and accompanying text (discussing "blame and shame" as tools of criminal justice).

unconventional but promising means.[6] It has defunded the academics and policy reformers who would endorse or even study innovative approaches to drug use and abuse.[7] And it has undermined localities that would implement alternatives.[8] The objective has never been to foster a healthier, caring collective. The objective is the drug-free society—full stop. Never mind that no society ever has or could achieve that end.

As authors, we might devote this entire essay to unpacking the reasons for the drug war's single-minded obsession with punitive prohibition. It is enough, however, briefly to flag three principal influences. First, the drug war's monomaniacal preoccupation with punitive prohibition lies partially in America's puritanical history and worldview.[9] Second, and to a greater degree, punitive prohibition is rooted in racism.[10] Third, and more subtly, the logic of punitive prohibition follows a distinctly legalistic mindset—a fixation with rules. Punitive prohibition is what happens when public policy is left to conventional lawyers, law enforcers, and central planners to be shaped from the top down. The war on drugs exposes particular drawbacks of law, legal institutions, and the legal turn of mind: all have a tendency toward the infant's infatuation with clear rules, the sociopath's obsession with intimidation and strength, and the coward's aversion to risk and experimentation.[11]

We do not mean, here, to disparage all legal regimes or bureaucratic frameworks. Some have great virtue and value. But they have a tendency to fall prey to blinkered perspectives that not only make for misguided public policy but also complicate course correction. Legal officials and bureaucrats grasp at bright-line answers, preferring wrongheaded simplicity to nuanced solutions.

[6] *See, e.g.*, *infra* notes 183–88 and accompanying text (discussing activists' efforts towards, and governmental pushback against, the establishment of needle exchanges to combat the spread of communicable diseases).

[7] *See, e.g.*, *infra* notes 241–43 (discussing impediments to medical cannabis research).

[8] *See, e.g.*, *infra* notes 235–37 and accompanying text (describing the interplay between local officials and state legislators).

[9] *See generally* BETTINA MUENSTER AND JENNIFER TRONE, WHY IS AMERICA SO PUNITIVE? A REPORT ON THE DELIBERATIONS OF THE INTERDISCIPLINARY ROUNDTABLE ON PUNITIVENESS IN AMERICA (2015), https://www.jjay.cuny.edu/sites/default/files/news/Punitiveness_in_America_Report_March2016.pdf [https://perma.cc/X39Q-55NJ] (analyzing the reasons behind America's emphasis on punitive criminal punishment).

[10] *See supra* note 4 and accompanying text.

[11] *See* Josh Bowers, *Legal Guilt, Normative Innocence, and the Equitable Decision Not to Prosecute*, 110 COLUM. L. REV. 1655, 1691 (2010) (quoting RICHARD A. POSNER, HOW JUDGES THINK 99 (2008)) ("[L]egal formalism may produce a kind of childishness—an inability to interact with the uncertainties of the real world and an eagerness to retreat to 'structures of authority' that substitute hollow make-believe for life in fact. Put simply, legal training facilitates incuriosity by emphasizing hierarchical and rule-bound thinking."); Josh Bowers, *Probable Cause, Constitutional Reasonableness, and the Unrecognized Point of a "Pointless Indignity*," 66 STAN. L. REV. 987, 1048–49 (2014) (discussing legal culture and the lawyer's turn of mind). *See generally* Duncan Kennedy, *Legal Education and the Reproduction of Hierarchy*, 32 J. LEGAL EDUC. 591 (1982) (discussing ideology, political attitudes, and hierarchical structure of legal education).

On this reasoning, punitive prohibition takes on a certain elegance, captured by the directive to "*Just Say No*."[12] One might dismiss this drug war missive as no more than an anodyne, state-sponsored public service message. But those three words succinctly describe much more: a century of state-sponsored aggression against its own people, a crusade against science, reason, compassion, public health, equal concern, and respect.

Yet now, in the face of a brutal opioid crisis, there is a modicum of energy for genuine drug policy reform—for a shift from the prevailing "*Just Say No*" mentality. The shift is welcome, of course. Still, it is hard to get too excited about a newfound enthusiasm that is, in itself, seemingly grounded in racial bias. White America has opened its collective eyes to the evils of the drug war at the very moment that the opioid epidemic has begun to plague rural and predominantly white communities.[13] If Derrick Bell still lived, he might shrug. We are witnessing a paradigmatic example of his "interest convergence" theory in action, which posits that white America will only see fit to help black America if white Americans are forced to face the same challenges as black Americans.[14] Simply put, there are limits to a polity's moral imagination when the problem exists *over there* only.

All the same, we are pragmatic drug policy reformers. And, because real lives hang in the balance, we'll take what we can get. Any port in a storm, as they say—any opportunity to shift the narrative, however slightly, from "criminal justice menace" to "public health crisis."

This is not to say that meaningful and effective reform was entirely absent in the decades before the current crisis. There have always been change agents, struggling as best they can, underground and in the shadows. Who were these frontline warriors? Rarely public officials, at least not initially. Nor were they policy wonks or other experts from the professional-thinking classes: they were the community members and movement people—men and women toiling in the trenches.[15] These courageous few have called out the drug war for what it is—a prudish instrument of oppression and a nonsensical and deadly illusion, rooted

[12] *See Her Causes*, RONALD REAGAN PRESIDENTIAL FOUND. & INST., https://www.reaganfoundation.org/ronald-reagan/nancy-reagan/her-causes/ [https://perma.cc/FYN8-5QRT] [hereinafter *Her Causes*] (discussing Nancy Reagan's 1980s "*Just Say No*" advertising campaign).

[13] Jenae Addison, *How Racial Inequity Is Playing Out in the Opioid Crisis*, PBS NEWSHOUR (July 18, 2019, 5:24 PM), https://www.latimes.com/science/sciencenow/la-sci-sn-opioids-whites-doctors-20190211-story.html [https://perma.cc/N8AW-QERW]; Melissa Healy, *Why Opioids Hit White Areas Harder: Doctors There Prescribe More Readily, Study Finds*, L.A. TIMES (Feb. 11, 2019, 8:35 AM), https://www.latimes.com/science/sciencenow/la-sci-sn-opioids-whites-doctors-20190211-story.html [https://perma.cc/2BJ6-ZHAZ].

[14] *See* Derrick A. Bell, Jr., Brown v. Board of Education *and the Interest-Convergence Dilemma*, 93 HARV. L. REV. 518, 523 (1980).

[15] *See* JOHANN HARI, CHASING THE SCREAM: THE FIRST AND LAST DAYS OF THE WAR ON DRUGS 195–203 (1st ed. 2015) (describing grassroots activism of Vancouver's drug users).

in fear and flawed science. For these street activists (in their capacity as brothers, sisters, parents, partners, friends, neighbors, co-workers, and even users), the war against the drug war has been a war of self-defense—a war waged by foot soldiers fighting for their lives and the lives of others.

In this essay, we intend to do a lot in a little space. In Part II, we recall a time, before our century-long war on drugs, when we did things differently—when we responded to an opioid epidemic not with prohibition but with a compassionate intervention known as addiction maintenance—that is, providing drugs, often free of charge, in amounts calibrated to maintain the wellbeing of dependent persons.[16] We examine what changed, and how we came to abandon that "harm reduction" model.[17] In Part III, we explore contemporary—often-grassroots—international efforts to return to an old-style, harm reduction approach. In the process, we explore some of the advantages of addiction maintenance in its modern form. In Part IV, we discuss how, when, and why addiction maintenance works. In Part V, we evaluate what stands in the way of addiction maintenance—namely, the leviathan of a coercive criminal justice system comprised of centralized policymakers who are convinced that they comprehend drug dependency better than treatment providers, medical professionals, and the users themselves. Finally, in Part VI, we survey a host of domestic reform efforts, and we provide a framework for understanding when, how, and to what extent these (often underground) endeavors have beaten back the leviathan.

As these multifaceted reform efforts reveal, addiction maintenance is only one front in a grassroots revolution. Indeed, additional reforms necessarily must precede addiction maintenance, because the practice is appropriate only after the failure of other much needed therapeutic interventions—like medication-

[16] *See* ALEX KREIT, CONTROLLED SUBSTANCES: CRIME, REGULATION, AND POLICY 739–40 (2013) (discussing addiction maintenance).

[17] By way of explanation, harm reduction models focus on minimizing the negative social, economic, and physical externalities that flow from human behaviors. In other words, "harm reduction is both a cure and a care-based approach consistent with accepting a duty of care as a compassionate and caring community, and while harm reduction encompasses abstinence as a desirable goal, it recognizes that when abstinence is not possible, it is not ethical to ignore the other available means of reducing human suffering." Ingrid Van Beek, *Harm Reduction—An Ethical Imperative*, 104 ADDICTION 341, 343 (2009) (emphasis omitted) (footnotes omitted). On the other hand, drug prohibition focuses entirely on abstinence—also termed *use* or *prevalence reduction*—backed by the cudgel of criminal justice. Robert J. MacCoun, *Moral Outrage and Opposition to Harm Reduction*, 7 CRIM. L. & PHIL. 83, 84 (2013); Jonathan P. Caulkins & Peter Reuter, *Setting Goals for Drug Policy: Harm Reduction or Use Reduction*, 92 ADDICTION 1143, 1145–46 (1997); *see also* Robert J. MacCoun & Peter Reuter, *Assessing Drug Prohibition and Its Alternatives: A Guide for Agnostics*, 7 ANN. REV. L. & SOC. SCI. 61, 63 (2011). *See generally* ROBERT J. MACCOUN & PETER REUTER, DRUG WAR HERESIES: LEARNING FROM OTHER VICES, TIMES, AND PLACES (2001) (analyzing American drug policy in historical context). By way of analogy, imagine two methods for promoting sexual health—providing free condoms or criminalizing contraceptives. Harm reduction describes the first approach; prohibition describes the second. *See infra* note 216 and accompanying text.

assisted treatment with methadone, buprenorphine, or suboxone, none of which are uniformly available at present.[18] Thus, we conclude with a pragmatic six-point plan, designed to address the current opioid crisis in a manner that abandons the logic of prohibition in favor of activism and—above all—a commitment to the Hippocratic oath to do no harm.

II. EARLY ADDICTION MAINTENANCE EFFORTS

Throughout the nineteenth century, drugs remained mostly unregulated.[19] Users purchased product through mail order catalogues and at local pharmacies.[20] Sears & Roebuck sold syringes with doses of injectable cocaine for a dollar or two.[21] Opiates were packaged into serums with delightfully alliterative names, like "Mrs. Winslow's Soothing Syrup."[22] And, critically, this legal market was substantially safer than the modern-day criminal market:

> Before the ban, almost all opiate users would buy a mild form of the drug at their corner store for a small price. A few did become addicts, and that meant their lives were depleted, in the same way that an alcoholic's life is depleted today. . . . But virtually none of them committed crimes to get their drug, or became wildly out of control, or lost their jobs. Then the legal routes to the drug were cut off—and all the problems we associate with drug addiction began: criminality, prostitution, violence.[23]

Medical professionals of the era considered opioid abuse a public health problem.[24] The idea of a *criminal* drug war would likely have seemed as foreign to them as a modern criminal war on poor diet as a means to fight type 2 diabetes today.[25] To the contrary, doctors regarded persons suffering from drug addiction as patients deserving of treatment.[26] Even for the profoundly dependent, the

[18] *See, e.g.*, PETER REUTER, CAN HEROIN MAINTENANCE HELP BALTIMORE? 1 (2009), http://www.abell.org/sites/default/files/publications/cja_HeroinMaintenance_0209.pdf [https://perma.cc/CB6F-NV22].

[19] *See generally* ALFRED R. LINDESMITH, THE ADDICT AND THE LAW (1965) (discussing the history of federal drug policy in the United States).

[20] ALEXANDER COCKBURN & JEFFREY ST. CLAIR, WHITEOUT: THE CIA, DRUGS AND THE PRESS 71 (1998).

[21] *Id.*

[22] HARI, *supra* note 15, at 35.

[23] *Id.* at 226.

[24] Ellen M. Weber, *Failure of Physicians to Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. HEALTH CARE L. & POL'Y 49, 56 (2010) ("[T]he medical community viewed addiction as a medical problem, and physicians prescribed opioid medications for the care of addicted patients without legal restrictions.").

[25] *See* David T. Courtwright, *The Hidden Epidemic: Opiate Addiction and Cocaine Use in the South*, 1860–1920, 49 J. SOUTHERN HIST. 57, 72 (1983) (discussing the growing number of physicians who saw addiction as a disease rather than a moral failing).

[26] *Id.*

medical profession provided a form of palliative care—often termed addiction maintenance—by which cravings were treated by access to the craved substance.[27]

By the turn of the century, the push for prohibition had begun—conceived of, principally, as a means to control minority communities.[28] Politicians, pastors, and the press drew specious links between drug abuse and the exploitation of white women.[29] These early drug warriors pushed for aggressive state responses, playing on vile canards of violent or sexually aggressive African-Americans with cocaine, Mexican-Americans with marijuana, and Chinese-Americans with opium.[30] African-Americans were singled out for especially harsh treatment. Unsubstantiated claims linked black drug abuse to "many of the horrible crimes committed in the Southern States," thus providing another convenient excuse for all varieties of Jim Crow persecution and oppression, including continued disenfranchisement.[31]

[27] HARI, *supra* note 15, at 34 (quoting Henry Smith Williams) ("[T]he doctor knows just what should be done . . . that he has but to write a few words on the prescription blank that lies at his elbow, and the patient . . . will receive the remedy that would restore him miraculously to a semblance of normality. . . ."); *id.* at 37 ("[Edward Williams] helped to build a free clinic for addicts, and he volunteered his own time there. He wrote his prescriptions for whoever needed them."). *See generally* HENRY SMITH WILLIAMS, DRUG ADDICTS ARE HUMAN BEINGS (1938) (discussing contemporary drug law and policy).

[28] *See generally* Hamilton Wright, *The International Opium Commission*, 3 AM. J. INT'L L. 828 (1909) (discussing government responses to increased opium use).

[29] HARI, *supra* note 15, at 17 (describing the racist belief that marijuana made African-American men "forget the appropriate racial barriers—and unleashed their lust for white women").

[30] *See, e.g.*, Alyssa Pagano, *The Racist Origins of Marijuana Prohibition*, BUSINESS INSIDER (Mar. 2, 2018, 10:57 AM), https://www.businessinsider.com/racist-origins-marijuana-prohibition-legalization-2018-2 [https://perma.cc/32AB-V4V4]; Edward Huntington Williams, *Negro Cocaine "Fiends" Are a New Southern Menace: Murder and Insanity Increasing Among Lower-Class Blacks Because They Have Taken to "Sniffing" Since Deprived of Whisky by Prohibition*, N.Y. TIMES, Feb. 8, 1914, at 12 (reporting on a "negro . . .'running amuck' in a cocaine frenzy, [who] had [purportedly] attempted to stab a storekeeper, and was [allegedly] . . . 'beating up' the various members of his own household"); *How Did We Get Here? History Has a Habit of Repeating Itself*, ECONOMIST (Aug. 14, 2018), https://www.economist.com/special-report/2018/08/14/how-did-we-get-here [https://perma.cc/B8YM-MCBV] (describing early twentieth century perception of "drug-crazed, sex-mad negroes" and "Chinese 'coolies,' brought into California to build railways and dig mines"). Notably, Harry Anslinger—the first commissioner of the Federal Bureau of Narcotics—was an unapologetic bigot, who waged a ruthless, and almost bizarrely personal and obsessive, campaign against African-American jazz singer and drug user, Billie Holliday. HARI, *supra* note 15, at 17–32; *Harry Jacob Anslinger*, DEA MUSEUM, https://deamuseum.org/anslinger/in-charge/ [https://perma.cc/24MG-MK6G].

[31] *See, e.g.*, DAVID F. MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL 7 (3d ed. 1999) (describing "fantasies characterized [by] white fear, not the reality of cocaine's effects" that "coincided with the peak of lynchings, legal segregation, and voting laws all designed to remove political and social power from [African-Americans]"); Courtwright, *supra* note 25, at 71 (describing the "supercharged racial atmosphere" and

Then, as now, whites used drugs at rates comparable to—and perhaps even higher than—other populations.[32] Indeed, historian David Courtwright concluded that "southern whites [of the era] had the highest addiction rate[s] of any regional racial group in the country, and perhaps one of the highest in the world."[33] But, among more privileged populations, it seems that drug abuse was still considered no worse than an unfortunate-but-tolerable vice.[34] In other words, attitudes about recreational drugs were shaped by caste and class—by the desire to prevent the "wrong" type from associating with the "right" type. Unsurprisingly, then, the first shots of the drug war were, like most shots since, targeted strikes against poorer and darker communities.[35]

What did early regulation look like? In 1914, Congress passed the Harrison Narcotics Tax Act, which taxed, but did not wholly prohibit, the production and distribution of cocaine and opioids.[36] In this way, doctors could still prescribe narcotics, and many continued to do so to treat dependence.[37] In fact, several municipalities ran public addiction maintenance clinics, including opioid clinics in New York City, Los Angeles, New Orleans, Shreveport, Atlanta, New Haven, Albany, and Jacksonville.[38] These dispensaries operated aboveground, granting prescriptions to users to ingest hard drugs.[39] Health officials not only treated users by feeding cravings, but also tracked patients.[40] Participants were required to register with the state, which minimized the risk of diversion of the drugs into

"exaggerated reactions to isolated but potently symbolic deeds" by the white southern power structure); *Cocaine Sniffers: Use of the Drug Increasing Among Negros in the South*, N.Y. DAILY TRIBUNE, June 21, 1903, at 11.

[32] JOHN HELMER & THOMAS VIETORISZ, DRUG USE: THE LABOR MARKET AND CLASS CONFLICT 12 (1974) (finding that whites used drugs at higher rates than African-Americans in early twentieth century America); *Criminal Justice Fact Sheet*, NAACP, https://www.naacp.org/criminal-justice-fact-sheet/ [https://perma.cc/QS8W-A4W3].

[33] Courtwright, *supra* note 25, at 57.

[34] *See* HARI, *supra* note 15, at 35–36.

[35] *See generally* William J. Stuntz, *Race, Class, and Drugs*, 98 COLUM. L. REV. 1795 (1998) (describing the contemporary drug war as a function of class, with race as its correlate).

[36] Harrison Narcotics Tax Act of 1914, Pub. L. No. 223, 38 Stat., 785, 785 (Dec. 17, 1914) (repealed 1970) [hereinafter Harrison Act].

[37] HARI, *supra* note 15, at 37.

[38] MUSTO, *supra* note 31, at 151; HARI, *supra* note 15,at 37; Courtwright, *supra* note 25, at 59; Weber, *supra* note 24, at 58–59 ("[F]ederal and state health officials and local law enforcement, beginning around 1912, created maintenance clinics in a dozen states that would prescribe medication in an effort to prevent suffering related to addiction and wean individuals from their drug use through the gradual reduction of dosage." (footnote omitted)).

[39] Courtwright, *supra* note 25, at 60 (analyzing the data and observing that the clinics were "designed to supply narcotics to, as well as keep track of, addicts").

[40] *Id.*

criminal markets and provided potential data to measure success empirically—even though such studies were apparently relatively uncommon at the time.[41]

It seems that the efforts were largely successful. If nothing else, they initially enjoyed widespread support from city councils, boards of health, and even local law enforcement.[42] According to the Los Angeles Mayor, the city's maintenance clinic did "more good . . . in one day than all the prosecutions in one month."[43] But the legal landscape was shifting. Initially, law enforcement focused on the so-called "script doctors" who liberally dispensed opioids to patients.[44] Federal prosecutors argued that addiction maintenance failed to qualify under the Harrison Act's allowance for "good faith" prescriptions "in the course of . . . professional practice."[45] And the Supreme Court would come largely to credit that claim. First, in *Webb v. United States*, the Court held that a doctor was prohibited from prescribing to "an habitual user" a dose of morphine, where the doctor's intention was not to "cure . . . the habit" but to keep the patient "comfortable by maintaining his customary use."[46] Subsequently, in *United States v. Behrman*, the Court decided that violating the Harrison Act did not require intent.[47] This ruling, combined with the *Jin Fuey Moy* holding before it, meant that "prescribing drugs for an addict was a crime regardless of the physician's intent in the matter,"[48] and a prescription could not "cater to the appetite . . . of one addicted to the use of the drug."[49] In *Linder v. United States*, however, the Court seemed to endorse a different approach:

[41] *See* Weber, *supra* note 24, at 59 ("In Tennessee, persons with addictions were registered and given refillable opiate prescriptions to minimize suffering and reduce illegal drug trafficking.").

[42] MUSTO, *supra* note 31, at 151, 156–78.

[43] HARI *supra* note 15, at 37.

[44] Thomas M. Quinn & Gerald T. McLaughlin, *The Evolution of Federal Drug Control Legislation*, 22 CATH. U. L. REV. 586, 595 (1973) ("[L]aw enforcement officials soon began to move to curtail the medical profession's freedom to prescribe narcotics in the treatment of addicts.").

[45] Harrison Act, *supra* note 36; *see also* KREIT, *supra* note 16, at 739–40 (describing cases "in which physicians argued that prescribing narcotics for addiction maintenance—in other words, to keep addicted patients from suffering withdrawal symptoms—was a legitimate medical use"); Jin Fuey Moy v. United States, 254 U.S. 189, 194 (1920).

[46] Webb v. United States, 249 U.S. 96, 99–100 (1919) ("[T]o call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required.").

[47] United States v. Behrman, 258 U.S. 280, 288 (1922).

[48] RUFUS KING, THE DRUG HANG-UP: AMERICA'S FIFTY-YEAR FOLLY 42 (1st ed. 1972) (emphasis omitted).

[49] *Jin Fuey Moy*, 254 U.S. at 194 (holding that the physician's exemption did not include "a distribution intended to cater to the appetite or satisfy the craving of one addicted to the use of the drug," and noting that a "'prescription' issued" for addiction maintenance "protects neither the physician who issues it nor the dealer who knowingly accepts and fills it").

> [Addicts] are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purposes solely because he has dispensed to one of them, in the ordinary course and in good faith . . . morphine or cocaine for relief of conditions incident to addiction.[50]

But *Linder* would prove *sui generis*—an exception to the dominant rule, as applied to a case where the doctor had prescribed only a relatively small dose.[51] The Harrison Act had set the stage for punitive prohibition.[52] And, with the passage of the Eighteenth Amendment, the logic of prohibition became a constitutional mandate.[53] This shifting legal landscape apparently reshaped cultural norms, in turn.[54] Enforcement of the Harrison Act "stigmatized medication-assisted treatment as well as the patients who received such care."[55] In short order, the practice of addiction maintenance disappeared.[56] By 1925, the last clinic had closed.[57]

With the repeal of the Eighteenth Amendment in 1933,[58] there was, perhaps, some hope that the state might soften its approach to prohibition *writ large*. To the contrary, federal officials, relieved of alcohol interdiction duties, were free to devote even more time and criminal justice energy to narcotics.[59] Remarkably, there is even some suggestion that law enforcement pivoted hard to controlled substances at the urging of organized crime, which hoped to keep physicians out of the prescription business and thereby to dominate criminal markets for recreational drugs.[60] In this way, our first federal drug war was an

[50] Linder v. United States, 268 U.S. 5, 18 (1925) ("What constitutes *bona fide* medical practice must be determined upon consideration of evidence and attending circumstances.").

[51] *See id.*; LINDESMITH, *supra* note 19, at 6–7 (discussing early Supreme Court drug cases).

[52] *See* LINDESMITH, *supra* note 19, at 3–5.

[53] Weber, *supra* note 24, at 57–59 (discussing the federal government's ever-more vigorous enforcement of the Harrison Act after alcohol prohibition).

[54] *See generally* Symposium, *The Legal Construction of Norms*, 86 VA. L. REV. 1577 (2000).

[55] Weber, *supra* note 24, at 56.

[56] *See id.* at 58–60 ("The American Medical Association issued a resolution in 1920 opposing ambulatory maintenance clinics and condemning the use of heroin, which sanctioned the further prosecution of physicians who continued to prescribe maintenance medication." (footnote omitted)).

[57] *Id.* at 60.

[58] *Eighteenth Amendment*, ENCYCLOPEDIA BRITANNICA, https://www.britannica.com/topic/Eighteenth-Amendment [https://perma.cc/YU7R-R8CV].

[59] *See* HARI, *supra* note 15, at 40 (discussing Henry Smith Williams' book "laying out . . . evidence that the entire policy of drug prohibition in America was a gigantic racket" and the "crackdown" was encouraged by organized crime).

[60] *Id.* at 40–41 ("Henry Smith Williams urged the public to ask: Why would gangsters pay the cops to enforce the drug laws harder? . . . Drug prohibition put the entire narcotics industry into their hands. Once the clinics were closed, every single addict became a potential customer and cash cow.").

act of aggression against doctors and patients. The doctor was the principal, the patient was his accessory, and both were made objects and subjects of prohibition and penology.

The government had its reasons, of course, to worry about unscrupulous physicians who indiscriminately dispensed opioids and other narcotics (just as authorities today have good reasons to worry about "pill mills").[61] There is a real concern about the diversion of prescription drugs into criminal markets.[62] And the line is fine between *treating* and *creating* drug dependency. But criminal law is allergic to such fine distinctions. Thus, the Harrison Act replaced the physician's armamentarium with the heavy weaponry of the criminal justice system. "The unfortunate consequence of this policy was to drive from the field of drug treatment not only the unethical 'script doctor' but the legitimate doctor as well."[63]

III. INTERNATIONAL PUBLIC HEALTH EFFORTS

Beyond our borders, a number of cities and countries have, for some time, successfully provided free, uncontaminated, and comparatively safe narcotics to persons addicted to controlled substances. Closest to home, Vancouver has witnessed a grassroots campaign, undertaken by drug users—the Vancouver Area Network of Drug Users (VANDU)—to support and care for each other.[64] VANDU initially established an underground supervised injection facility: a sterile medically staffed environment to which recreational users may bring drugs to consume in relative safety.[65] And, as VANDU's successes became apparent, it took its efforts mainstream.[66] It pressured the municipality to declare a public health emergency and won the support of the city's conservative mayor, Philip Owen.[67] Thereafter, Vancouver opened Insite, the first licit drug-

[61] *See* Quinn & McLaughlin *supra* note 44, at 594–95; *see also infra* notes 140–41 and accompanying text (discussing "pill mills").

[62] Khary K. Rigg et al., *Patterns of Prescription Medication Diversion Among Drug Dealers*, 19 DRUGS 144, 144 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3365597/pdf/nihms-347430.pdf [https://perma.cc/Q7LN-Z3EL].

[63] Quinn & McLaughlin, *supra* note 44, at 595.

[64] HARI, *supra* note 15, at 197–202; Matthew Power, *The Alleys of Vancouver*, SLATE (Feb. 3, 2010, 9:54 AM), https://slate.com/news-and-politics/2010/02/the-alleys-of-vancouver.html [https://perma.cc/9LV4-AHBA].

[65] Ryan McNeil et al., *"People Knew They Could Come Here to Get Help": An Ethnographic Study of Assisted Injection Practices at a Peer-Run "Unsanctioned" Supervised Drug Consumption Room in a Canadian Setting*, 3 AIDS & BEHAVIOR 473, 475 (2013), https://link.springer.com/content/pdf/10.1007%2Fs10461-013-0540-y.pdf [https://perma.cc/VX7Q-QPG2] ("VANDU opened an 'unsanctioned' supervised drug consumption room . . . in accordance with a strict harm reduction policy."); *see* HARI, *supra* note 15, at 202–03.

[66] HARI, *supra* note 15, at 200 ("Suddenly, VANDU was an international news story . . . from the BBC to the *New York Times*.").

[67] *Id.* at 200–02.

consumption safe site in North America.[68] Drug users who brought their drugs to Insite were made safe in three ways: they were insulated from arrest and prosecution, they were given sterile injection equipment and other drug use paraphernalia, and they were supervised by medical professionals prepared to administer naloxone and oxygen as needed to reverse overdoses.[69]

The results were transformative. To date, Insite claims to have reversed nearly 5000 overdoses without suffering a single overdose death.[70] More than that, clean needles have kept injectable-drug users from transmitting communicable diseases, like HIV and hepatitis.[71] And, as drug injectors have moved their habits—and their needles—indoors, quality of life in Vancouver's formerly derelict Downtown Eastside has improved dramatically.[72] Many heavy drug users have reduced or even ceased their drug use and have secured stable employment and housing.[73] These results are in keeping with recent research, which traces addiction primarily to trauma and social isolation and only secondarily to chemical dependence.[74] The current line is that "the opposite of addiction is connection," and, by normalizing but still discouraging drug use, these international experiments have served to reconnect dependent drug users with their communities.[75]

[68] *Id.* at 202–03.

[69] Lopez, *infra* note 76 and accompanying text.

[70] JoNel Aleccia, *As Seattle Eyes Supervised Drug-Injection Sites, Is Vancouver a Good Model?*, SEATTLE TIMES, https://www.seattletimes.com/seattle-news/health/is-vancouvers-safe-drug-use-site-a-good-model-for-seattle/ [https://perma.cc/X8NB-WL7A] (last updated May 22, 2017, 1:00 PM).

[71] *Id.*; *see also* HARI, *supra* note 15, at 203 (noting sharp drop in drug-related fatalities in British Columbia as a whole); Robert Matas, *B.C. Drug Deaths Hit a Low Not Seen in Years*, GLOBE & MAIL, https://www.theglobeandmail.com/news/national/bc-drug-deaths-hit-a-low-not-seen-in-years/article1067082/ [https://perma.cc/QPL7-FHR6] (last updated Apr. 28, 2018). *See generally* Canada v. PHS Cmty. Services Soc'y, 3 S.C.R. 134, 147–48 (2011) (describing the work and impact of VANDU).

[72] *See* Evan Wood et al., *Changes in Public Order After the Opening of a Medically Supervised Safer Injecting Facility for Illicit Injection Drug Users*, 171(7) CANADIAN MED. ASS'N. J. 731, 733 (2004) ("Our observations suggest that the establishment of the safer injecting facility has resulted in measurable improvements in public order, which in turn may improve the liveability of communities and benefit tourism while reducing community concerns stemming from public drug use and discarded syringes."). Notably, between 1996 and 2006, life expectancy in the Downtown Eastside rose by several years. Sam Cooper, *"I Don't Want to Die Here": Residents Buoyed by Stats Showing People in Poorest Area Living Longer*, PROVINCE (Sept. 7, 2012). Easy access to clean needles would seem to be an obvious factor contributing to increased longevity in the area. *Id.*

[73] *See* DRUG POL'Y ALLIANCE, *infra* note 201 (describing Canadian "opioid-maintenance therapy" that has "decreased drug use and crime").

[74] HARI, *supra* note 15, at 170–75; *infra* notes 112–13 and accompanying text (discussing the environmental theory of addiction).

[75] *See, e.g.*, Robert Weiss, *The Opposite of Addiction Is Connection: New Addiction Research Brings Surprising Discoveries*, PSYCHOL. TODAY (Sept. 30, 2015), https://www.psychologytoday.com/us/blog/love-and-sex-in-the-digital-age/201509/the-opposite-addiction-is-connection [https://perma.cc/44PK-MXXS].

But, ultimately, the safe site was not enough to serve effectively the needs of drug-affected Vancouver communities. Thus, the city opened the Providence Crosstown Clinic, which operates on a genuine addiction maintenance model.[76] At Crosstown, staff provide addicts with medical-grade heroin in a supervised setting with care sometimes paid for by Health Canada (the country's national public healthcare provider).[77] The program reaches the very individuals that criminal legal systems label repeat offenders.[78] Indeed, many participants previously have cycled through Canadian jails and prisons—to no avail.[79] Out of desperation and as a last resort, the city turned to free heroin, making patients out of run-of-the-mill recidivists.[80] At Crosstown—and contrary to the prevailing ideology of punishment—recidivism is no mark of blameworthiness; rather, it is the price of admission. Pharmaceutical-grade heroin is made available to patients for whom all other interventions have failed, such as medication-assisted therapy with methadone, buprenorphine, or suboxone.[81]

The aim is palliative care.[82] First, harm is reduced to the opioid-dependent person by providing clean needles in a clinical setting and drugs of predictable quality, unadulterated by more toxic substances like fentanyl.[83] Second, harm is reduced to the public by minimizing the incentives of drug seekers to commit property and violent crimes to feed drug habits.[84] The operating philosophy is not American-style prohibition and use reduction.[85] To the contrary, there is little expectation that habitual users will even taper in the near future.[86] The idea is to transform the heavy drug user into a functional and socially productive individual who need not spend every waking moment evading law enforcement to furtively score and use illicit substances of unknown purity, potency, and provenance.[87] To that end, the clinic offers additional services, like social

[76] German Lopez, *The Case for Prescription Heroin*, VOX (June 12, 2017), https://www.vox.com/policy-and-politics/2017/6/12/15301458/canada-prescription-heroin-opioid-addiction [https://perma.cc/MVB3-LXK5].

[77] *Id.*

[78] *Id.* (discussing a Crosstown patient who served time in prison for robberies committed to feed a drug habit).

[79] *Id.*

[80] *Id.* ("These patients are the people for whom other treatments have failed. It's a last resort. And it works."); *cf.* Josh Bowers, *What If Nothing Works? On Recidivism, Crime Licenses, and Public Health* (unpublished manuscript) [on file with *Ohio State Law Journal*] (reexamining recidivism through a public health lens).

[81] Lopez, *supra* note 76.

[82] *See generally id.*

[83] *Id.*

[84] *Id.*

[85] *See supra* note 17 and accompanying text (comparing harm reduction and use reduction approaches).

[86] *See generally* Lopez, *supra* note 76 ("But we don't arbitrarily say, 'Okay, you've been with us for six months. It's time to reduce your dose.' There's a study out of Belgium—they have injectable treatment there—that shows if you just arbitrarily stop people, they will go back to using illicit opioids.").

[87] *Id.*

workers and other health care and treatments, designed to help participants maintain social connections and construct lives of meaning, even as participants remain drug dependent.[88]

Vancouver's efforts built upon those of a collection of mainly European countries that also have fashioned innovative harm reduction interventions, including the establishment of addiction maintenance programs. Dating back to the 1980s, the city of Liverpool, England experimented with prescription "heroin reefers"—cigarettes soaked in heroin.[89] Although few data were developed or kept, a police study showed that criminal convictions for drug-addicted persons dropped from 6.88 convictions per individual in the eighteen months prior to enrollment, to only 0.44 convictions in the eighteen months thereafter.[90]

Likewise, Switzerland opened addiction maintenance clinics in the 1990s.[91] Today, there are twenty-three of these clinics treating over two thousand heroin dependent persons.[92] Predictably, the country has enjoyed a marked decline in communicable diseases, as well as drops in incidences of crimes associated with drug use.[93] And the percentage of participants with full-time employment has tripled, while dependence upon welfare has declined dramatically.[94] In turn, harm reduction efforts have grown in popularity. In 2008, sixty-eight percent of voters approved a measure to incorporate addiction maintenance into the country's official health policy.[95]

Portugal has implemented even more ambitious harm reduction measures, and it has achieved even greater success. By the end of the last century, a staggering (and depressing) one percent of Portugal's population was hooked on heroin.[96] In 2001, the government decriminalized possession and use (but not

[88] *See* Lopez, *supra* note 76.

[89] HARI, *supra* note 15, at 210.

[90] Linnet Myers, *Europe Finds U.S Drug War Lacking in Results*, CHI. TRIB. (Nov. 2, 1995), https://www.chicagotribune.com/news/ct-xpm-1995-11-02-9511020238-story.html [https://perma.cc/63EA-VKP6].

[91] HARI, *supra* note 15, at 219. *See generally* JOHN STRANG ET AL., EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, EMCDDA INSIGHTS: NEW HEROIN-ASSISTED TREATMENT (2012).

[92] Gaëlle Faure, *Why Doctors Are Giving Heroin to Heroin Addicts*, TIME (Sept. 28, 2009), http://content.time.com/time/health/article/0,8599,1926160,00.html [https://perma.cc/FR83-NF6J].

[93] *See, e.g.*, HARI, *supra* note 15, at 221 (noting drop in HIV infections caused by injection drug use from sixty-eight to five percent); Joanne Csete & Peter J. Grob, *Switzerland, HIV and the Power of Pragmatism: Lessons for Drug Policy Development*, 23 INT'L J. DRUG POL'Y 82, 84 (2012) (noting drop in hepatitis infections caused by injection drug use from fifty-one to ten percent); Denis Ribeaud, *Long-Term Impacts of the Swiss Heroin Prescription Trials on Crime of Treated Heroin Users*, 34 J. DRUG ISSUES 163, 173 (noting fifty percent reduction in vehicle thefts among participants).

[94] HARI, *supra* note 15, at 222.

[95] KREIT, *supra* note 16, at 740.

[96] Lauren Frayer, *In Portugal, Drug Use Is Treated As a Medical Issue, Not a Crime*, NPR (Apr. 18, 2017, 4:55 AM), https://www.npr.org/sections/parallels/2017/04/18/

sale) of all drugs and invested heavily in treatment and social services.[97] A decade later, Portuguese rates of drug use remained relatively high but stable, but rates of hard drug use declined.[98] And, more to the point, drug-related HIV infections plummeted *over ninety percent* and overdose deaths fell *eighty-five percent*—to the lowest death rate in Western Europe and *one-fiftieth* the rate in the United States.[99] As Nicholas Kristof remarked: "Portugal may be winning the war on drugs—by ending it."[100]

IV. HOW, WHEN, AND WHY ADDICTION MAINTENANCE WORKS

Why have these international efforts proven so successful? For one thing, they are finely targeted to the challenges facing dependent drug users and are designed deliberately to help those users at critical moments. Heroin and other opioids are prescribed only after misguided and coercive penology has failed miserably.[101] Moreover, addiction maintenance promotes safety: the drugs must be consumed on site—in comfortable but sterile settings with well-equipped medical personnel on hand, thereby minimizing risks of death and the diversion of opioids into criminal markets.[102] Finally, these efforts are oriented in the right way—against the logic of prohibition.[103] The operating philosophy, here, is that a criminal war on drugs is destructive.[104] Isolation and othering produce

524380027/in-portugal-drug-use-is-treated-as-a-medical-issue-not-a-crime [https://perma.cc/JMN7-JEM2].

[97] *See id.*

[98] HARI, *supra* note 15, at 249.

[99] *Id.* at 249–50, 268; Naina Bajekal, *Want to Win the War on Drugs? Portugal Might Have the Answer*, TIME (Aug. 1, 2018), https://time.com/longform/portugal-drug-use-decriminalization/ [https://perma.cc/2QBZ-ZTW7]; Caitlin Elizabeth Hughes & Alex Stevens, *What Can We Learn from the Portuguese Decriminalization of Illicit Drugs?*, 50 BRITISH J. CRIMINOLOGY 999, 999 (2010); Christopher Ingraham, *Why Hardly Anyone Dies from a Drug Overdose in Portugal*, WASH. POST (June 5, 2015), https://www.washingtonpost.com/news/wonk/wp/2015/06/05/why-hardly-anyone-dies-from-a-drug-overdose-in-portugal/ [on file with *Ohio State Law Journal*]; Nicholas Kristof, *How to Win a War on Drugs*, N.Y. TIMES (Sept. 22, 2017), https://www.nytimes.com/2017/09/22/opinion/sunday/portugal-drug-decriminalization.html [https://perma.cc/27FH-MPUY]; Frayer, *supra* note 96.

[100] Kristof, *supra* note 99. Uruguay, Belgium, Germany, Sweden, and the Netherlands have undertaken similar harm reduction reforms with similarly promising results. *See, e.g.*, HARI, *supra* note 15, at 264–73; Shirley Haasnoot, *Dutch Drug Policy, Pragmatic As Ever*, GUARDIAN (Jan. 3, 2013), https://www.theguardian.com/commentisfree/2013/jan/03/dutch-drug-policy-pragmatic [https://perma.cc/99F4-ZPEH].

[101] *See, e.g.*, Lopez, *supra* note 76.

[102] *Id.*

[103] Lopez, *supra* note 76; *see* Harry G. Levine & Craig Reinarman, *From Prohibition to Regulation: Lessons from Alcohol Policy to Drug Policy*, 69 MILLBANK Q. 461, 464 (1991).

[104] *See, e.g.*, Jacob G. Hornberger, *The Deadly and Destructive Futility of the Drug War*, FUTURE FREEDOM FOUND. (Apr. 4, 2019), https://www.fff.org/2019/04/04/the-deadly-and-destructive-futility-of-the-drug-war/ [https://perma.cc/9CXJ-TL95].

antisocial behavior.[105] And blame and shame—coins of the criminal justice realm—produce isolation and othering.[106]

Again, the goal of addiction maintenance is harm reduction—a reduction in the harms that flow from criminal drug markets, from infectious diseases, from overdoses, and from criminal enforcement and punishment.[107] And, because addiction maintenance is an intervention of last resort (not unlike "heroic" measures in medicine),[108] it promises to reduce harm most for the most dependent users.[109] For these seeming lost causes, for whom nothing has worked, addiction maintenance provides the possibility to stay off the streets, with families, in jobs, and out of emergency rooms, hospitals, jails, and mortuaries.[110]

And, even though addiction maintenance is intended only to provide palliative care, there is some evidence that—under the right circumstances—it reduces overall drug use.[111] This would seem counterintuitive, of course. How could it be that free access to opioids might help dependent users get clean? Appreciate, first, the context in which drugs are most often abused. The environmental theory of addiction insists that pharmacology is only secondarily related to dependence.[112] Chemicals have physiological effects to be sure, but plenty of drug users (so-called "chippers") maintain relative free will to ingest (or not) without becoming dependent.[113] Indeed, the vast majority of persons

[105] *See, e.g.*, Shabnam Javdani et al., *Expanding Our Lens: Female Pathways to Antisocial Behavior in Adolescence and Adulthood*, 31 Clinical Psychol. Rev. 1324, 1339 (2011), https://reader.elsevier.com/reader/sd/pii/S0272735811001553?token=CC5C13BB7D3828A011B918A171B12BCFF792A76412D93DA856ABD19E4AB837EC44A1B10E13EF802C253953607A160AB6 [https://perma.cc/52LC-FFUL] (stating that isolation "increases the likelihood of further engagement in antisocial behavior" in sex workers).

[106] *Cf.* JOEL FEINBERG, DOING AND DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY 98 (1970) (defining punishment as "'hard treatment'" with a "reprobative function").

[107] *See, e.g.*, Julia Lowe Behr, *Methadone Maintenance Therapy for Opioid Addiction*, Clinician Reviews (June 18, 2008), https://www.mdedge.com/clinicianreviews/article/72298/pain/methadone-maintenance-therapy-opioid-addiction [https://perma.cc/9QST-CM8E].

[108] *See Heroic*, THE AMERICAN HERITAGE STEDMAN'S MEDICAL DICTIONARY (2d ed. 2004) (defining "heroic" measures as last-ditch efforts to address a medical problem).

[109] *See, e.g.*, Lopez, *supra* note 76.

[110] *Id.*

[111] *See, e.g.*, HARI, *supra* note 15, at 197–202.

[112] *See, e.g.*, *id.* at 170–75.

[113] Josh Bowers, *Contraindicated Drug Courts*, 55 UCLA L. REV. 783, 801–02 n.80 (2008); MALCOLM GLADWELL, THE TIPPING POINT: HOW LITTLE THINGS CAN MAKE A BIG DIFFERENCE 234–38 (2002) (discussing nicotine chippers); Gene M. Heyman, *Is Addiction a Chronic, Relapsing Disease?*, *in* DRUG ADDICTION AND DRUG POLICY: THE STRUGGLE TO CONTROL DEPENDENCE 86 (Philip B. Heymann & William N. Brownsberger eds., 2001) (noting that chippers are "able to regulate their intake so that their drug use does not interfere with other aspects of their life"); Stephen J. Morse, *Hooked on Hype: Addiction and*

who try even hard drugs manage to avoid dependence.[114] A small subset develop powerful compulsions, but the question of when and whether these compulsions take hold may turn more on an individual's life circumstances than the chemical composition of the drug.[115]

This is the environmental theory of addiction.[116] Consider the many heroin-dependent American soldiers fighting in Vietnam who readily gave up the substance once they returned home safely.[117] These men self-medicated against the horrors of war but were able to alter their behavior once the context had changed.[118] More to the point, consider a series of animal studies.[119] In an early set of studies, rats were placed alone in cages with food, water, and cocaine drips.[120] In short order, most rats abandoned their food and water and fixated on the cocaine, consuming copious amounts until death.[121] At first blush, the studies seemed to demonstrate the intensity of chemical hooks.[122] But, decades later, social scientists replicated the studies with a clever twist: several rats were housed together in nurturing environments, not in isolation in sterile cages; they were given ample opportunities to interact and socialize.[123] These rats still experimented with the cocaine, but not to excess and less so over time.[124] Like the drug dependent soldiers in Vietnam, the first set of rats were self-medicating against the pain and loneliness. The second set enjoyed meaningful lives. They had less desire or compulsion to fill the void with self-harm.[125]

Now, consider the life of a drug user suffering under punitive prohibition. Hers is an often miserable existence. She hides from a surveillance state—in the shadows and on the margins—devoting her mental and physical energy to unlawful projects in service of her habit. She furtively seeks and finds product of dubious quality, quantity, and safety. She lacks the resources and support to chart a healthier and more productive path. The effect is criminogenic.

Responsibility, 19 LAW & PHIL. 3, 19 (2000) (defining "chippers" as those who "use potentially addicting substances regularly, but do not develop an addiction").

[114] *See* Bowers, *supra* note 113, at 801.

[115] *See, e.g.*, HARI, *supra* note 15, at 171–73 (discussing rat studies that demonstrated how environment shapes dependency and comparing the results to findings on declining drug use among soldiers returning from Vietnam).

[116] *Id.*

[117] *Id.* at 173.

[118] *Id.*

[119] *Id.* at 171–73.

[120] *Id.*

[121] HARI, *supra* note 15, at 171–73.

[122] *Id.*

[123] *Id.* at 172–73.

[124] *Id.*

[125] *Id.* at 172. On this logic, it is easier to understand also how people become addicted even to habits that feature no internal chemical hooks—gambling or pornography, for instance. These habits are likewise driven by context. To be sure, internal brain chemistry impacts the degree to which an individual engages compulsively in even nonchemical habits. But environmental factors, in turn, shape the way in which an individual's brain chemistry operates.

According to Gabor Maté, a doctor specializing in childhood trauma and addiction:

> If I had to design a system that was intended to keep people addicted, I'd design exactly the system that we have right now . . . I'd attack people, and ostracize them . . . the more you stress people, the more they're going to use. The more you de-stress people, the less they're going to use. So to create a system where you ostracize and marginalize and criminalize people, and force them to live in poverty with disease, you are basically guaranteeing they will stay at it.[126]

Doctor Maté has been criticized for overstating the influence of isolation and trauma, while underplaying pharmacological effects.[127] But the Vancouver and European experiences suggest strongly that the isolation and trauma created by prohibition are causing substantial harm.[128] When these governments abandoned blame and shame, and focused instead on eliminating barriers to drug acquisition, drug users were better able to focus on self-improvement.[129] Their ties to family, community, education, and employment were strengthened (or at least left intact).[130] Thus, for instance, a *Lancet* study found that the majority of participants in Switzerland's addiction maintenance clinics were able to pivot eventually to methadone or abstinence programs.[131] Moreover, as Vancouver's Downtown Eastside discovered, fewer people are likely to become drug dependent in the first instance once a neighborhood's quality of life improves—that is, once the social environment gets better.[132]

[126] *Id.* at 166. *See generally id.* at 155–67 (discussing Gabor Maté's work).

[127] Stanton Peele, *The Seductive (But Dangerous) Allure of Gabor Maté*, PSYCHOL. TODAY (Dec. 5, 2011), https://www.psychologytoday.com/us/blog/addiction-in-society/201112/the-seductive-dangerous-allure-gabor-mat?page=2 [https://perma.cc/84U6-XSFE].

[128] *See, e.g.*, Aleccia, *supra* note 70; Faure, *supra* note 92.

[129] *See, e.g.*, Lopez, *supra* note 76.

[130] *See id.*

[131] REUTER, *supra* note 18, at 3; *see also* HARI, *supra* note 15, at 221–22 (discussing how in Switzerland "[t]he number of addicts dying every year fell dramatically" after the clinics opened).

[132] *See supra* notes 71–73 and accompanying text (describing Vancouver's harm reduction interventions, improvements in quality of life, and reductions in drug use). This last point sounds in the "broken-windows" theory of policing. *See* Josh Bowers, *Grassroots Plea Bargaining*, 91 MARQ. L. REV. 85, 94 (2007). In practice, that theory has been criticized (and rightly so) for morphing into policies of mandatory arrest and zero-tolerance for public order crimes. *See id.* at 95–96. But, at least in its initial formulation, the theory emphasized flexibility and problem solving—improving quality of life by many means (only one of which was arrest), in an effort to reduce harm and cultivate socially productive norms and conduct. *Id.* at 94 ("In its initial incarnation, proponents of the broken-windows theory . . . believed that the policy worked best by decentralizing police response to public disorder to increase enforcement flexibility and effectiveness. Implementation turned on providing police ample discretion . . . ." (internal citations omitted)). *See generally* George L. Kelling & James Q. Wilson, *Broken Windows*, ATLANTIC (Mar. 1982), https://www.the

The conclusion is inescapable. Addiction need not be a terminal condition. And, for the most dependent, the most promising treatment may just be to feed the habit.[133] If nothing else, addiction maintenance facilitates the process known as "aging out."[134] Heavy drug abuse and other risk-taking behaviors concentrate in populations of young adult men.[135] As the individual matures, he tends to use less.[136] (The reader need look no further than the acquaintance who drinks less now than he did in high school or college.) And the more stable a person's life is, the likelier he is to "age out" more quickly.[137] The takeaway is obvious (even if often ignored): sometimes the best approach is patience—to wait out drug dependence, and, in the interim, to minimize the damage done to the individual and his social network.

This is what addiction maintenance programs are designed to achieve. They try to keep the hopeless addict alive, relatively healthy, and socially integrated long enough to navigate, eventually, to the other side of the age divide—to steer clear of the most destructive and deadly byproducts of punitive prohibition.[138]

V. THE LEVIATHAN

But isn't the current opioid crisis a product of a prescription market and model? Drug manufacturers pushed opioids on doctors.[139] And "pill mills"—the pharmacies and physicians who overprescribed and over-dispensed

atlantic.com/magazine/archive/1982/03/broken-windows/304465/ [https://perma.cc/3PVD-ZRP7].

[133] Gavin Bart, *Maintenance Medication for Opiate Addiction: The Foundation of Recovery*, 31 J. ADDICTIVE DISEASES 207, 207 (2012) ("Results indicate that maintenance medication provides the best opportunity for patients to achieve recovery from opiate addiction.").

[134] Maia Szalavitz, *Most People With Addiction Simply Grow Out of It. Why Is This Widely Denied?*, PACIFIC STANDARD, https://psmag.com/social-justice/people-addiction-simply-grow-widely-denied-91605 [https://perma.cc/FN53-TKNU] (last updated June 14, 2017).

[135] *See, e.g.*, LAURA DUBERSTEIN LINDBERG ET AL., TEEN RISK-TAKING: A STATISTICAL PORTRAIT 22 (2000), https://aspe.hhs.gov/system/files/pdf/72851/TeenRiskTaking.pdf [https://perma.cc/6VY5-QFVG] (discussing statistics on risk-taking behaviors in adolescent males).

[136] *See, e.g.*, Szalavitz, *supra* note 134.

[137] *Id.*; *see, e.g.*, HARI, *supra* note 15, at 171–73.

[138] HARI, *supra* note 15, at 212 ("Most addicts will simply stop, whether they are given treatment or not, provided prohibition doesn't kill them first."); RICHARD LAWRENCE MILLER, THE CASE FOR LEGALIZING DRUGS 53 (1991) ("Researchers have found chronological age to be a prevalent reason for drug abuse. Abuse is typically a young person's habit, given up as the individual matures. Most opiate addicts relinquish their drug within 10 years." (footnote omitted)).

[139] Michael Nedelman, *Doctors Increasingly Face Charges for Patient Overdoses*, CNN (July 31, 2017), https://www.cnn.com/2017/07/31/health/opioid-doctors-responsible-overdose/index.html [https://perma.cc/542L-XY8L].

medications—pushed opioids on patients.[140] In short, America already has subscribed to a drug-licensing regime, and it led primarily to lives ruined and families and communities splintered.[141] If prescriptions and addiction maintenance are so promising, what went so wrong?

The short answer is that recent American experience cannot be understood as addiction maintenance. Under addiction maintenance, opioid users who have failed to respond to other kinds of treatment, including methadone maintenance, are admitted into medically supervised clinics and provided pharmaceutical-grade narcotics in amounts calibrated to maintain their social and physical well-being.[142] The American approach is, in fact, the opposite of addiction maintenance. Our prevailing licensing regime permits doctors to prescribe opioids only until patients become dependent.[143] A recently passed Michigan statute captures the ethos, defining "good faith" practice as "the prescribing or dispensing of a controlled substance . . . in the regular course of professional treatment . . . for a pathology or condition *other than that individual's physical or psychological dependence upon or addiction to a controlled substance*."[144] Once patients get hooked, the American criminal justice takes precedence, displacing "individualized medicine" and patient-centered care with the protocols of mandatory tapering and cessation.[145]

The logic seems simple enough—fewer pills prescribed corresponds with less use by the drug dependent. And, indeed, prescription opioid use has dropped

[140] Pia Malbran, *What's a Pill Mill?*, CBS NEWS (May 31, 2007, 6:01 PM), https://www.cbsnews.com/news/whats-a-pill-mill/ [https://perma.cc/6Y4W-NTPG] ("'Pill mill' is a term used primarily by local and state investigators to describe a doctor, clinic or pharmacy that is prescribing or dispensing powerful narcotics inappropriately or for non-medical reasons.").

[141] *See, e.g.*, CNN Wire Service, *10 People Died of Overdoses Within 26 Hours in 1 Ohio County*, FOX6 NOW (Sept. 30, 2019), https://fox6now.com/2019/09/30/10-people-died-of-overdoses-within-26-hours-in-one-ohio-county/ [https://perma.cc/9H4K-Q5W7] ("As of about 10 a.m. this morning we have had 10 people die of overdoses in about 26 hours . . . .").

[142] *See* Lopez, *supra* note 76.

[143] *See* H. Westley Clark & Karen Lea Sees, *Opioids, Chronic Pain, and the Law*, 8 J. PAIN & SYMPTOM MGMT. 297, 299 (1993) ("When a physician writes an opioid prescription, care must be taken to determine whether the person is an addict.").

[144] MICH. COMP. LAWS § 333.7333 (1978) (amended 2018) (emphasis added); *see also* Clark & Sees, *supra* note 143, at 299.

[145] Susan Buckles, *4 Ways Individualized Medicine Can Be Applied Immediately to Patient Care*, MAYO CLINIC: NEWS NETWORK (Oct. 5, 2016), https://newsnetwork.mayoclinic.org/discussion/4-ways-individualized-medicine-can-be-applied-immediately-to-patient-care/ [https://perma.cc/9UH8-U7JN] (defining "individualized medicine" as "the concept that prediction, diagnosis, treatment and, eventually, prevention can be matched to an individual patient based on genetics, environment and lifestyle"); *see, e.g.*, Lev Facher, *Tapered to Zero: In Radical Move, Oregon's Medicaid Program Weighs Cutting Off Chronic Pain Patients from Opioids*, STAT (Aug. 15, 2018), https://www.statnews.com/2018/08/15/oregon-medicaid-tapering-opioids/ [https://perma.cc/4ZUN-978G] (discussing daily caps and mandatory tapering).

dramatically in recent years.[146] Prescriptions peaked in 2012 and have fallen since.[147] In 2017 alone, they plummeted ten percent, the sharpest decline in a quarter century.[148] But current enforcement efforts have succeeded only in minimizing prescription drug use and the diversion of prescription drugs into illicit markets.[149] At the same time, prescription drug users have been redirected into those same markets—markets characterized by crime and death, prosecution and punishment.[150] Put simply, a downtick in prescription drug availability translates into an uptick in street-level demand for street-manufactured drugs.[151] Criminal buyers replace patients.[152] Syringes replace pills.[153] Laced heroin replaces pharmaceutical-grade opioids.[154] According to Johann Hari:

> If I am an American who has developed an Oxycontin addiction, as soon as my doctor realizes I'm an addict, she has to cut me off. She is allowed to prescribe to treat only my physical pain—not my addiction. . . . That's when, in desperation, I might hold up a pharmacy with a gun, or go and buy unlabeled pills from street dealers. Most of the problems attributed to prescription drugs in the United States . . . begin here, when the legal, regulated route to the drug is terminated. . . . the prescription drug crisis doesn't discredit legalization—it shows the need for it.[155]

[146] Art Levine, *The Government's Solution to the Opioid Crisis Feels Like a War to Pain Patients*, HUFFPOST (July 31, 2018), https://www.huffpost.com/ [https://perma.cc/5WJN-VAC5] (search in search bar for "Art Levine opioid"; then follow "The Government's Solution" hyperlink); *see U.S. Opioid Prescribing Rate Maps*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html [https://perma.cc/C98R-7ZLS].

[147] *U.S. Opioid Prescribing Rate Maps*, *supra* note 146.

[148] Levine, *supra* note 146.

[149] Darius Tahir, *Databases Key to Trump's Crackdown on Opioids*, POLITICO (June 29, 2018), https://www.politico.com/story/2018/06/29/databases-key-crackdown-on-opioids-686879 [https://perma.cc/QA45-CNET].

[150] *See id.*

[151] *See id.*

[152] *Id.* ("[T]here's evidence that thousands of prescription users cut off by fearful doctors are turning to these dangerous street drugs, or being left to suffer. Many addicted patients end up in legal trouble before they are offered help.").

[153] *See Prescription Opioids*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/drugfacts/prescription-opioids [https://perma.cc/XAA3-24XY] (last updated June 2019) ("In some places, heroin is cheaper and easier to get than prescription opioids, so some people switch to using heroin instead.").

[154] *See generally What Is Heroin Cut With?*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/heroin-treatment/cut-with [https://perma.cc/9KPD-57KV] [hereinafter *What Is Heroin*].

[155] HARI, *supra* note 15, at 226.

The data bear out Hari's claims. Even as opioid prescriptions have plummeted,[156] opioid-linked deaths have skyrocketed.[157] The economics of the street trade produce unreliable doses that fluctuate in quality between exceptionally weak and strong.[158] One dealer may find it profitable to dilute a batch and sell more.[159] Another dealer may cut costs by adding cheap fentanyl—an extremely potent and highly lethal synthetic opioid for which even seasoned opioid users may lack tolerance.[160] More to the point, a given dealer may not even be aware of the purity and potency of their own unlabeled and unregulated product.[161] And comparatively milder prescription drugs, which were so plentiful on pharmacy shelves, are often just too expensive and bulky for street-level sellers to keep in stock.[162]

Recent so-called reform efforts have made the problem only worse. The current war on opioids is, like the first war on drugs, a war on physicians.[163] In the words of former Attorney General Jeff Sessions: "'[W]e're going to target those doctors.'"[164] In January 2018, the Drug Enforcement Administration (DEA) initiated a "surge" in efforts to shut down pill mills.[165] The next month, the Justice Department started a task force to go after manufacturers and distributors.[166] According to a press release: "The Department will . . . use all

[156] Terrence McCoy, *"Unintended Consequences,"* WASH. POST (May 31, 2018), https://www.washingtonpost.com/graphics/2018/local/impact-of-americas-opioid-crackdown/?utm_term=.1a5d37da09ab [https://perma.cc/629M-LQCH]; THE IQVIA INST. FOR HUMAN DATA SCI., MEDICINE USE AND SPENDING IN THE U.S.: A REVIEW OF 2017 AND OUTLOOK TO 2022 20 (2018), https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/medicine-use-and-spending-in-the-us-a-review-of-2017-and-outlook-to-2022.pdf?_=1563500255652 [on file with *Ohio State Law Journal*] (finding that opioid prescriptions shrank 29% between 2011 and 2017).

[157] Levine, *supra* note 146 (describing rise in opioid deaths); Tahir, *supra* note 149.

[158] *What Is Heroin*, *supra* note 154.

[159] *Id.* ("[D]rug dealers will add other drugs or non-intoxicating substances to the drug so they can sell more of it at a lesser expense to themselves.").

[160] *See Fentanyl*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/drugfacts/fentanyl [https://perma.cc/P7A6-EVA2] (last updated Feb. 2019).

[161] *See What Is Heroin*, *supra* note 154.

[162] *See* HARI, *supra* note 15, at 231. According to Johann Hari: "On the streets, Oxy is three times more expensive than heroin—way beyond the price range of most addicts. . . . Just as when all legal routes to alcohol were cut off, beer disappeared and whisky won, when all legal routes to opiates are cut off, Oxy disappears, and heroin prevails. This isn't a law of nature . . . [it's] drug policy." *Id.*

[163] *See* Nedelman, *supra* note 139.

[164] McCoy, *supra* note 156.

[165] Levine, *supra* note 146 (internal quotations omitted).

[166] Press Release, U.S. Dep't of Justice, Attorney General Sessions Announces New Prescription Interdiction & Litigation Task Force (Feb. 27, 2018), https://www.justice.gov/opa/pr/attorney-general-sessions-announces-new-prescription-interdiction-litigation-task-force [https://perma.cc/5ZXL-XEYW] ("Attorney General Jeff Sessions today announced the creation of a new effort, the Department of Justice Prescription Interdiction & Litigation (PIL) Task Force, to fight the prescription opioid crisis.").

criminal and civil tools at its disposal to hold distributors such as pharmacies, pain management clinics, drug testing facilities, and individual physicians accountable for unlawful actions . . . to prevent diversion and improper prescribing."[167] In March, the administration announced plans to cut opioid prescriptions by a third within three years, and the DEA initiated new drug-production quotas, ultimately producing dramatic opioid shortages.[168] In June, Sessions announced charges against 162 individuals for crimes related to prescribing and distributing prescription opioids.[169] And, even before this recent crackdown, the DEA had increased actions against doctors from 88 in 2011 to 479 in 2016.[170]

Nor is the escalation and crackdown unique to federal law enforcement. The Center for Disease Control (CDC) has promulgated its own guidelines for prescribing higher dosages.[171] Initially, the CDC implemented these guidelines as recommendations only, but several states and medical boards have enacted their own statutory and regulatory limits to fit within the CDC guidelines.[172]

[167] *Id.*

[168] *See* Levine, *supra* note 146.

[169] *See* Attorney General Jeff Sessions, Attorney General Sessions Delivers Remarks Announcing National Health Care Fraud and Opioid Takedown (June 28, 2018), https://www.justice.gov/opa/speech/attorney-general-sessions-delivers-remarks-announcing-national-health-care-fraud-and [https://perma.cc/Y7VX-5N43] ("In this latest operation, with the help of our fabulous partners at HHS, we have charged another 162 people—including 32 doctors—with the illegal distribution of opioids.").

[170] Nedelman, *supra* note 139.

[171] CTRS. FOR DISEASE CONTROL & PREVENTION, CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN—UNITED STATES, 2016 (Mar. 2016), https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm [https://perma.cc/Q4W9-KR2G].

[172] *See, e.g.*, OFFICE OF GOVERNOR DOUG DUCEY, ARIZONA OPIOID EPIDEMIC ACT 13 (2018), https://azgovernor.gov/sites/default/files/related-docs/arizona_opioid_epidemic_act_policy_primer.pdf [https://perma.cc/HL7F-X3SJ] (limiting daily dosage levels to mirror CDC guidelines); Erika Ferrando, *New AR Medical Board Guidelines Limit Opioid Over-Prescribing*, THV11, https://www.thv11.com/article/news/health/opioids/saving-a-generation/new-ar-medical-board-guidelines-limit-opioid-over-prescribing/91-575266199 [https://perma.cc/QG7E-9RX4] (last updated July 18, 2018) (discussing new Arkansas policy that sets "excessive" opioid prescription practices at just over half the daily CDC guideline); *Opioid Prescription Limits and Policies by State*, BALLOTPEDIA https://ballotpedia.org/Opioid_prescription_limits_and_policies_by_state [https://perma.cc/TA6C-WHQK] (discussing implementation of opioid prescription limits in various states in response to opioid epidemic); Patty Wight, *Intent on Reversing Its Opioid Epidemic, a State Limits Prescriptions*, NPR (Aug. 23, 2017), https://www.npr.org/sections/health-shots/2017/08/23/543955887/intent-on-reversing-its-opioid-epidemic-a-state-limits-prescriptions [https://perma.cc/RPA4-YZ4V] (describing new Maine standards). *See generally* Andy Marso, *Opioid Backlash: Kansas Citians in Chronic Pain Say Fewer Doctors Will Prescribe Meds*, KAN. CITY STAR (Sept. 2, 2018), https://www.kansascity.com/news/business/health-care/article217447815.html [https://perma.cc/93NE-GV46] [hereinafter Marso *Opioid*] ("The non-binding guidelines were not a blanket ban on

Likewise, public and private insurers have imposed their own tapering protocols.[173]

In turn, physicians have changed practices or gotten out of the business altogether. Consider the DEA's pursuit of Dr. Forest Tennant, a prominent California physician, who faced criminal investigation for atypical prescribing.[174] Tennant specialized in severe, chronic pain and was world-renowned for palliative care, often at the end of life.[175] He had evidence-based reasons for prescribing such large quantities of opioids.[176] Nevertheless, law enforcement successfully pushed Tennant into early retirement, leaving his patients to suffer without effective pain management.[177]

This is over-deterrence in action—just another example of the manner by which punitive prohibition chills socially valuable conduct at the margins.[178]

prescribing opioids for chronic pain. But they've changed how states regulate doctors at a time when some physicians who specialize in treating pain thought they were already being unfairly targeted."). By way of further example, the state of Missouri announced that it plans to crack down on 8,000 doctors for over-prescribing opioids. Andy Marso, *Greitens Announces Opioid Crackdown That Could Affect 8,000 Missouri Doctors*, KAN. CITY STAR, https://www.kansascity.com/news/business/health-care/article203576419.html [https://perma.cc/89WZ-Y8W3] (last updated Mar. 6, 2018) [hereinafter Marso *Greitens*]. The number is astonishing, considering that there are only 19,000 physicians in the entire state. *Id.*

[173] *See, e.g.*, Facher, *supra* note 145 (noting daily caps and mandatory tapering); Marso *Greitens*, *supra* note 172 (describing Missouri HealthNet's new rule requiring prescribers to adhere to CDC guidelines); McCoy, *supra* note 156 (noting that "Medicare and large pharmacy chains such as CVS have since announced or imposed restrictions on opioid prescriptions").

[174] *See* Pat Anson, *Dr. Forest Tennant Retiring Due to DEA Scrutiny*, PAIN NEWS NETWORK (Mar. 26, 2018), https://www.painnewsnetwork.org/stories/2018/3/26/dr-forest-tennant-retiring-due-to-dea-scrutiny [https://perma.cc/5FML-9AHS] (detailing investigation of Tennant).

[175] *See id.*

[176] Forest Tennant, *Ultra-High Dose Opioid Therapy: Uncommon and Declining, but Still Needed*, PRAC. PAIN MGMT., https://www.practicalpainmanagement.com/treatments/pharmacological/opioids/ultra-high-dose-opioid-therapy-uncommon-declining-still-needed [https://perma.cc/22XZ-4D2E] (last updated Oct. 28, 2014) ("A small and uncommon subset of chronic pain patients will need more than 1,000 mg of morphine equivalents per day. . . . Patients who require ultra-high opioid doses can be identified by a history of standard opioid dose failure, family validation, physical examination, and laboratory evidence.").

[177] *See* Anson, *supra* note 174.

[178] Brianna Ehley, *How the Opioid Crackdown Is Backfiring*, POLITICO (Aug. 28, 2018), https://www.politico.com/story/2018/08/28/how-the-opioid-crackdown-is-backfiring-752183 [https://perma.cc/PJ6Q-LKRF] ("Many doctors and pharmacists . . . acknowledged such patients' predicament. But they said they feel under enormous pressure to limit the powerful painkillers and fearful of consequences, such as losing their licenses or even prison time, for inappropriate prescribing."); Levine, *supra* note 146 ("[T]he hard-line regulatory and enforcement approach . . . critics say doesn't distinguish between pill-mill doctors who deserve to be shut down and legitimate pain doctors who use high-dosage opioids."); Marso *Opioid*, *supra* note 172 ("The result . . . has been a chilling effect

Indeed, in some states, the wait to see a qualified pain management specialist has increased to a year or longer.[179] And it stands to reason that the ethical doctor may be dissuaded most: because they are comparatively risk averse, they may overcorrect to steer well clear of criminal justice.[180] Moreover, they are likelier to be aware of (and comply with) the heightened recordkeeping requirements that law enforcement uses to trawl for targets.[181] At a certain point, it's just not worth the effort. As one primary care doctor put it: "'I will no longer treat chronic pain. Period . . . . There is too much risk involved.'"[182]

VI. KICKING THE HABIT

Meaningful domestic drug reform (as modest as it has been) has only ever arisen from the bottom-up and against the grain. Take the example of syringe exchanges. Starting in Europe in the 1980s, activists experimented with exchanges as a response to the deadly epidemic of HIV/AIDS.[183] American reformers took note.[184] But federal and state governments worked actively against initiatives. The Drug Enforcement Administration, for example, had previously promulgated the Model Drug Paraphernalia Act, which provided a template for forty-six states to criminalize the manufacture, possession, or distribution of drug paraphernalia, broadly defined.[185] Moreover, the federal government refused to fund syringe exchanges until they were proven "safe and effective" (and, of course, it refused also to fund research into the question).[186] Indeed, Senator Jesse Helms "equated" any public effort to implement a syringe exchange as government-supported drug abuse.[187] Nevertheless, activists

nationally that has reduced the number of doctors willing to prescribe opioids and has left patients already dependent on them in the lurch.").

[179] *See, e.g.*, Katie Fairbanks, *Opioid Regulations Worry Chronic Pain Patients, Doctors*, U.S. NEWS (Sept. 22, 2018), https://www.usnews.com/news/best-states/washington/articles/2018-09-22/opioid-regulations-worry-chronic-pain-patients-doctors [https://perma.cc/74KD-WHTA].

[180] *See* Nedelman, *supra* note 139.

[181] *See* Tahir, *supra* note 149.

[182] Ehley, *supra* note 178.

[183] *See* Don C. Des Jarlais, *Harm Reduction in the USA: The Research Perspective and an Archive to David Purchase*, 14 HARM REDUCTION J. 1, 3 (2017).

[184] *See id.* at 3–4.

[185] Scott Burris et al., *The Legal Strategies Used in Operating Syringe Exchange Programs in the United States*, 86 AM. J. PUB. HEALTH 1161, 1161 (1996) (describing the Model Drug Paraphernalia Act as prohibiting "any equipment, product, or material of any sort, including hypodermic needles and syringes, intended to be used to introduce illicit or controlled substances into the body").

[186] Des Jarlais, *supra* note 183, at 3; *see also* 42 U.S.C. § 300ee-5 (1988) ("None of the funds provided under this Act . . . shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.").

[187] Richard Weinmeyer, *Needle Exchange Programs' Status in U.S. Politics*, 18 AMA J. ETHICS 252, 253 (2016).

persisted in doing what they could, typically underground.[188] And, over time, some mainstream stakeholders even began to buy in.[189] Ultimately, a number of municipal and state authorities authorized syringe exchange programs, maneuvering politically and legally to prevent pushback.[190] By 2015, even the federal government had lifted its funding ban—albeit only partially and more than a quarter century too late.[191] Overall, reform efforts proved successful, but only from the outside-in.

Take also the example of medical cannabis. Today, a majority of states have enacted laws permitting at least some form of medical use.[192] But these statutory public health interventions were slow in coming, even though, as early as the 1970s, it already was well established that cannabis could quell cancer patients' nausea and stimulate their appetites.[193] Indeed, by the early 1990s, patients and advocates had raised awareness that cannabis also could alleviate suffering from other illnesses and afflictions—glaucoma, AIDS-related wasting syndrome, epilepsy, neuropathic pain, and the side effects of ingesting certain drug cocktails.[194]

Nevertheless, the federal government remained intransigent. Even today, the Controlled Substances Act classifies marijuana as a Schedule I drug—a substance purported to have no medical use and a high potential for abuse.[195] Simply put, federal law criminalizes cannabis—almost anytime, anywhere, for anyone.[196] Still, activists found a way to build a grassroots political movement

[188] *See, e.g.*, *History of Health: Needle Exchange in San Francisco*, S.F. AIDS FOUND., https://www.sfaf.org/resource-library/needle-exchange-in-san-francisco/ [https://perma.cc/PY4V-85A8] (summarizing history of underground exchanges in San Francisco).

[189] Des Jarlais, *supra* note 183, at 4.

[190] *Id.*

[191] Consolidated Appropriations Act, Pub. L. No. 114-113, § 520, 129 Stat. 2652 (2015). *See generally* Weinmeyer, *supra* note 187.

[192] *See Medical Marijuana Map*, SCRIBD, https://www.scribd.com/document/394217841/Medical-Marijuana-Map [https://perma.cc/JQ3K-J2YN] (last updated May 2019) (mapping United States medical marijuana laws).

[193] N.M. STAT. ANN. § 26-2A-2 (West 1978). *See generally* LESTER GRINSPOON & JAMES B. BAKALAR, MARIHUANA, THE FORBIDDEN MEDICINE 4–7 (Yale U. Press rev. ed. 1997) (discussing early medical marijuana studies).

[194] INST. OF MED., MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE viii (Janet E. Joy et al. eds., 1999); Alex Kreit & Aaron Marcus, Raich, *Health Care, and the Commerce Clause*, 31 WM. MITCHELL L. REV. 957, 959 (2005).

[195] 21 U.S.C. § 812(c)(10) (2018); *see also* All. for Cannabis Therapeutics v. DEA, 15 F.3d 1131, 1134–35 (D.C. Cir. 1994) (upholding DEA order maintaining Schedule I classification); Kreit & Marcus, *supra* note 194, at 961.

[196] Peter Grinspoon, *Medical Marijuana*, HARV. HEALTH PUB., https://www.health.harvard.edu/blog/medical-marijuana-2018011513085 [https://perma.cc/G63M-QZUS] (last updated June 25, 2019) ("It is still illegal from the federal government's perspective."). The very narrow exception may be the Food and Drug Administration's "Investigational New Drug" program, which permits studies on medical cannabis in narrowly circumscribed settings. *E.g.*, ROBERT C. RANDALL & ALICE M. O'LEARY, MARIJUANA RX: THE PATIENTS' FIGHT FOR MEDICINAL POT 104–12 (1st ed. 1998).

around medical cannabis, establishing a collection of underground dispensaries.[197] Municipalities and states began to follow their lead, but, at first, only by citizen-initiated resolutions and referenda.[198] Policymakers only found the courage to act once the issue of medical cannabis had become obviously expedient.[199] Until then, the path to meaningful reform was direct democracy and direct action—below and around the apathy and even outright hostility of elected legislators.

To these examples, we could add the drug court movement, which now boasts over two thousand courts currently operating nationwide.[200] In the interest of full disclosure, we should make clear that the authors are deeply skeptical of the ability of drug courts to provide appropriate treatment and to function effectively as an alternative to incarceration (much less to avoid the collateral harms of the drug war).[201] More to the point, the drug court model embraces and perpetuates a prohibitionist and coercive paradigm of abstinence that we believe is misguided. The movement operates within criminal justice, retaining the threat of punishment as a backstop for the noncompliant

197 *See generally* Jordan Heller, *From Drug War to Dispensaries: An Oral History of Weed Legalization's First Wave*, NY INTELLIGENCER (Nov. 14, 2018), http://nymag.com/intelligencer/2018/11/marijuana-legalizations-first-wave-an-oral-history.html [https://perma.cc/L6TX-GDC7].

198 *See, e.g.*, GERMAINE Q. WONG, OFFICE OF THE REGISTRAR OF VOTERS, SAN FRANCISCO VOTER INFORMATION PAMPHLET & SAMPLE BALLOT 145–51 (1991); *Santa Cruz County Measure A Marijuana for Medical Use Initiative*, SCHAFFER LIBR. DRUG POL'Y, http://druglibrary.org/schaffer/hemp/medical/santcruz.htm [https://perma.cc/W93V-EKLA].

199 Erwin Chemerinsky et al., *Cooperative Federalism and Marijuana Regulation*, 62 UCLA L. REV. 74, 84–86 (2015) (summarizing the spread of state medical marijuana laws); *see, e.g.*, S.B. 119, 2008 Leg., 213th Sess. (N.J. 2009) (justifying medical marijuana legislation in New Jersey based on the growing number of states legalizing medical marijuana). *See generally* Heller, *supra* note 197 (describing the gradual increase in stakeholder support for a medical marijuana ballot initiative).

200 Bowers, *supra* note 113, at 784.

201 As both authors have examined elsewhere, court-imposed treatment depends upon a logical and normative flaw: the more typical drug court graduate is the least compulsive user; the genuinely addicted drug user, by comparison, is likelier to fail out and face a draconian termination sentence—a jail or prison sentence longer, perhaps, than even traditional drug penalties. Daniel N. Abrahamson, *The Substance Abuse and Crime Prevention Act of 2000: The Parameters and Promise of Proposition 36*, CAL. CRIM. DEF. PRAC. REP. 535, 536 (2001); Bowers, *supra* note 113, at 789, 792–98; Daniel N. Abrahamson, *Drug Courts are Not the Answer: Guest Commentary*, L.A. DAILY NEWS, https://www.dailynews.com/2015/05/12/drug-courts-are-not-the-answer-guest-commentary/ [https://perma.cc/J4DN-BNAX] (last updated Aug. 28, 2017, 7:03 AM). *See generally* DRUG COURTS ARE NOT THE ANSWER: TOWARD A HEALTH-CENTERED APPROACH TO DRUG USE, DRUG POLICY ALL. (2011), http://www.drugpolicy.org/drugcourts [https://perma.cc/6TWJ-B6CW] [hereinafter DRUG COURTS ARE NOT THE ANSWER]. For the genuinely addicted offender, court-mandated treatment typically provides only a brief respite from the traditional criminal justice cycle of capture, conviction, and incarceration. *See id.*

participant.[202] Disappointingly, but perhaps unsurprisingly, many leading drug court advocates have tended, therefore, to publicly oppose more ambitious drug policy reform:[203] decriminalization of cannabis,[204] even for medical use;[205] reduction of felony possession offenses to misdemeanor or noncriminal offenses;[206] and acceptance of (and reliance upon) medication-assisted treatments.[207]

But, putting these criticisms aside, the immediate point is only that the drug court movement has followed the familiar path. Its origins can be traced to a small handful of ground-level advocates (in this case, local judges and law enforcement) who could no longer countenance the most egregious excesses of the drug war (*to wit*, lengthy jail and prison sentences for low-level, nonviolent drug offenders).[208] With no other viable option, these officials began to experiment, first quietly, then vocally, with alternative judicial interventions intended to avoid draconian penalties for chemically dependent persons.[209]

[202] Bowers, *supra* note 113, at 792 ("[S]tudies found that the sentences for failing participants in New York City drug courts were typically two-to-five times longer than the sentences for conventionally adjudicated defendants.").

[203] It should be noted, however, that a small but growing minority of drug court treatment programs are not abstinence-only programs, and embrace medication-assisted treatment. Significantly, one of our symposium co-participants, the Honorable Fred Moses, is a drug court judge who runs an innovative (and welcome) medication-assisted treatment program. Spencer Remoquillo, *Judge Touts Success in Vivitrol Drug Court*, CHILLICOTHE GAZETTE (Sept. 5, 2015, 12:02 PM), https://www.chillicothegazette.com/story/news/crime/high-in-ohio/2015/09/05/judge-touts-success-vivitrol-drug-court/71719850/ [https://perma.cc/Y54B-66NV]. Of course, the program remains court-mandated, but we welcome its healthy rejection of an abstinence-only approach.

[204] *See In Debate of Legalizing Marijuana, Disagreement Over Drug's Dangers*, PEW RES. CTR. (Apr. 14, 2015), https://www.people-press.org/2015/04/14/in-debate-over-legalizing-marijuana-disagreement-over-drugs-dangers/ [https://perma.cc/Y2YK-XFFV].

[205] *See Voices from Both Sides of the Medical Marijuana Debate*, AM. ADDICTION CTRS., https://drugabuse.com/voices-from-both-sides-of-the-medical-marijuana-debate/ [https://perma.cc/ZT9P-TFKD].

[206] *See, e.g.*, Jessie Balmert, *What Is Ohio Issue 1? Separating Fact from Fiction on Divisive Drug Ballot Initiative*, WKYC3, https://www.wkyc.com/article/news/politics/elections/what-is-ohio-issue-1-separating-fact-from-fiction-on-divisive-drug-ballot-initiative/95-611365501 [https://perma.cc/6KB6-GLZY] (last updated Nov. 7, 2018, 7:19 AM).

[207] *See* Jeannette Pforr, *Medication-Assisted Treatment: A Solution or a Substitution*, IBH NEWS (Feb. 6, 2018), https://ibhsolutions.com/blog/medication-assisted-treatment/ [https://perma.cc/N6BK-SDNA].

[208] *See* Lauren Kirchner, *Remembering the Drug Court Revolution*, PAC. STANDARD, https://psmag.com/news/remembering-drug-court-revolution-80034 [https://perma.cc/WC4Z-MZ5Q] (last updated May 3, 2017) (describing efforts of criminal justice officials to establish and develop a drug court model).

[209] Michael C. Dorf & Charles F. Sabel, *Drug Treatment Courts and Emergent Experimentalist Government*, 53 VAND. L. REV. 831, 841–43 (2000) (discussing development of Miami-Dade drug court, which was spearheaded by officials who "actively

Let us return, now, to the subject of this symposium—the opioid epidemic. Until relatively recently, federal and state laws largely stymied persons who use opioids and their peers and family members from preemptively gaining access to naloxone, an opioid antagonist, which reverses overdoses.[210] Naloxone (trade-name Narcan) is called the "Lazarus" drug[211] for good reason: injecting naloxone into a person's bloodstream revives the sufferer by counteracting respiratory distress.[212] For a long time, however, possession of naloxone was limited principally to emergency medical technicians and emergency room doctors and nurses.[213] Thus, its benefits could reach only those overdose victims who lived long enough to see the inside of an ambulance or hospital.

Technically, some physicians still could prescribe naloxone, but any such efforts were resisted by public officials, law enforcement, and even many within the medical community.[214] In a classic example of retrograde use reduction reasoning, opponents of the Lazarus drug relied upon the specious argument that ready access to naloxone would encourage opioid users (antidote in hand) to use drugs more often and more recklessly.[215] The rationale should sound familiar to

sought more effective alternatives to incarceration," and describing subsequent diffusion of this model to other localities).

[210] *See* Corey S. Davis & Derek Carr, *Legal Changes to Increase Access to Naloxone for Opioid Overdose Reversal in the United States*, 157 DRUG & ALCOHOL DEPENDENCE 112, 113 (2015) (noting that until 2015 "a patchwork of laws and legal considerations" blocked many people's access to naloxone).

[211] Shankar Vedantam et al., *Life, Death, and the Lazarus Drug: Confronting America's Opioid Crisis*, NPR (June 24, 2019, 5:35 PM), https://www.npr.org/2019/06/24/735423620/life-death-and-the-lazarus-drug-confronting-americas-opioid-crisis [https://perma.cc/SYA5-AGJ4].

[212] *See* Daniel Kim et al., *Expanded Access to Naloxone: Options for Critical Response to the Epidemic of Opioid Overdose Mortality*, 99 AM. J. PUB. HEALTH 402, 403 (2009) ("Once administered, naloxone . . . effectively revers[es] potentially fatal opiate effects within a few minutes.").

[213] *See* Am. Soc'y Addiction Med., *Public Policy Statement on the Use of Naloxone for the Prevention of Opioid Overdose Deaths*, https://www.asam.org/docs/default-source/public-policy-statements/use-of-naloxone-for-the-prevention-of-opioid-overdose-deaths-final.pdf [https://perma.cc/56BT-Q6UY] (last updated Oct. 2016) ("Until relatively recently, only physicians and certain emergency medical personnel were authorized to administer naloxone to resuscitate opioid overdose victims.").

[214] *See, e.g.*, Leo Beletsky et al., *Physicians' Knowledge of and Willingness to Prescribe Naloxone to Reverse Accidental Opiate Overdose: Challenges and Opportunities*, 84 J. URB. HEALTH 126, 130, 132 (2006) (describing physicians' reluctance to prescribe naloxone); Jennifer L. Doleac & Anita Mukherjee, *The Moral Hazard of Lifesaving Innovations: Naloxone Access, Opioid Abuse, and Crime* 1–2 (IZA Inst. of Labor Econ., Discussion Paper No. 11489, 2018), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3170278 [on file with *Ohio State Law Journal*] (summarizing arguments against naloxone distribution); (summarizing arguments against naloxone distribution); Kim, *supra* note 212, at 403–04 (discussing objections to expanded access).

[215] Doleac & Mukherjee, *supra* note 214, at 1, 36 ("There is a concern, however, that widespread access to the safety net drug can unintentionally increase riskier opioid use and its related problems.").

anyone who has encountered the inane claim that giving contraceptives to teens induces promiscuity.[216] Here, as there, it is far better to minimize bad outcomes than it is to preach unrealistic abstinence. Naloxone is neither an addictive nor mind-altering chemical compound.[217] It is incapable of recreational abuse.[218] It is, first and foremost, a lifesaver.[219] To withhold it is to endorse the view that the wages of sin are death by overdose.

Enter the street activists—men and women who rejected the illogic and fatalism of prohibitionist thinking. Piggybacking on the highly successful work of a syringe exchange program initiated by the Chicago Recovery Alliance, activists began distributing naloxone to syringe exchange clients and taught them how to administer naloxone to reverse an overdose.[220] Days after distribution of the first naloxone vial, a "save" was recorded.[221] Hundreds, then thousands of saves followed.[222] Other syringe exchanges took note of the Chicago experiment, as did local public health departments.[223] In short order,

[216] Melissa Healy, *Does No-Cost Contraception Promote Promiscuity? No, Says Study*, L.A. TIMES (Mar. 6, 2014, 3:51 PM), https://www.latimes.com/science/sciencenow/la-sci-sn-contraceptives-sex-promiscuity-20140306-story.html [https://perma.cc/RH4D-57KN].

[217] *Understanding Naxolone*, HARM REDUCTION COAL., https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/ [https://perma.cc/3FZZ-GFCX] ("Naloxone is a nonscheduled (i.e., non-addictive), prescription medication.").

[218] *Id.* ("Naxolone has no potential for abuse.").

[219] *See id.*

[220] John Keilman, *Dan Bigg Remembered as 'Revolutionary' for Approach to Heroin Crisis, Pioneered Life-Saving Naloxone, Needle Handouts*, CHI. TRIB. (Aug. 22, 2018, 6:00 PM), https://www.chicagotribune.com/news/breaking/ct-met-dan-bigg-heroin-obituary-20180821-story.html [https://perma.cc/M9N3-PTJZ] ("A decade later, as heroin-related deaths began to surge, [the Chicago Recovery Alliance] pioneered the idea of putting the overdose-reversing medication naloxone into the hands of drug users and their loved ones.").

[221] *See id.*

[222] Don Terry, *A Shot That Saves the Lives of Addicts Is Now in Their Hands*, N.Y. TIMES (July 24, 2010), https://www.nytimes.com/2010/07/25/us/25cncnaloxone.html [https://perma.cc/Y3GT-NVX5] (noting that the Chicago Recovery Alliance reported roughly 2000 overdose reversals in the first nine years it began widely dispensing naloxone); *Chicago Recovery Alliance's Naloxone Distribution Saves Lives*, COMER FAM. FOUND., http://www.comerfamilyfoundation.org/articles/chicago-recovery-alliances-naloxone-distribution-saves-lives [https://perma.cc/4STA-2T9R] ("In the 18 years since CRA has taken this bottom-up approach of distributing naloxone, . . . the organization has received more than 6000 reports of users bringing someone back from a potentially deadly overdose.").

[223] *See* Press Release, Office of the Mayor, City of Chi., Mayor Emanuel, Chi. Dep't of Pub. Health Increase Cmty. Inv. to Fight Opioids (Mar. 8, 2018), https://www.chicago.gov/city/en/depts/cdph/provdrs/healthy_living/news/2018/march/mayor-emanuel--chicago-department-of-public-health-increase-comm.html [https://perma.cc/742L-PTQV] (describing the City of Chicago's investment in naloxone).

other communities began to distribute naloxone; thereafter, municipal and state-level law and policy reform followed.[224]

* * * *

Four dynamics describe each of these drug policy reforms. First, until harm reduction interventions are well-established, public officials and law enforcement agents are typically part of the problem, not the solution.[225] In each case, policymakers and professionals either initially opposed pragmatic harm reduction measures or stayed mum, fearing backlash.[226] There are political and market forces at work. The enforcers of the drug war participate in a multibillion-dollar criminal justice industrial complex—just as drug traffickers participate (illicitly and licitly) in multibillion-dollar drug distribution and pharmaceutical industrial complexes.[227] In each of these markets, there is a lot at stake. Criminal justice has its jail and prison cells; its paid prosecutors, judges, and police, probation, and corrections officers. The prescription drug industry has its drug representatives, scientific researchers, public relations professionals, and political lobbyists. Organized drug crime has its guns and safe houses; its gang members, foot soldiers, and street dealers. The pressure is tremendous to keep feeding the drug war machinery. No surprise, then, that institutional elites tend to make such bad insurgents.

Second, and relatedly, public health innovations typically start underground. For years—without any change in local, state, or federal law—sterile syringes were exchanged,[228] medical marijuana was ingested,[229] and naloxone was distributed and injected.[230] If "Just Say No" is the mantra of the drug war,[231] then the ethos of drug reform is Nike's trademark, "Just Do It."[232] Grassroots activists have proven willing to risk everything—at first quietly, then

[224] *Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws*, NETWORK FOR PUB. HEALTH L., https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf [https://perma.cc/4A3G-RFHW] (last updated Dec. 2018) (noting that while "community access to naloxone was historically limited by laws and regulations that pre-date the overdose epidemic," by July 2017 "all fifty states and the District of Columbia have now modified their laws to increase access to naloxone").

[225] *See supra* note 214.

[226] *See id.*

[227] *See* Linda Evans & Eve Goldberg, *"Prisons are Big Business:" The Prison-Industrial Complex and the Global Economy*, GLOBALRES., https://www.globalresearch.ca/prisons-are-big-business-the-prison-industrial-complex-and-the-global-economy/5328757 [https://perma.cc/3PPP-JNPB] (last updated Oct. 27, 2018).

[228] Keilman, *supra* note 220.

[229] Heller, *supra* note 197.

[230] Keilman, *supra* note 220.

[231] *Her Causes*, *supra* note 12 (summarizing history of "*Just Say No*" campaign).

[232] *See* Martin Kessler, *The Story Behind Nike's 'Just Do It' Slogan*, WBUR (Nov. 23, 2018), https://www.wbur.org/onlyagame/2018/11/23/just-do-it-nike-gilmore [https://perma.cc/M6CL-BDCN].

flagrantly—to defy an immoral system, by purposefully violating draconian drug laws.[233] For these courageous—and justifiably outraged—advocates, saving lives is worth the gamble. More to the point, it's often the only available bet against an all-powerful machine. Joseph William Singer once wrote: "What protects us against Nazism is not the belief that reason can prove that it is wrong. What protects us is outrage."[234] We don't mean to equate the American-led war on drugs with fascism (though the two ideologies do share certain features), but rather to posit that sometimes the best way to respond to state-sponsored infliction of harm is to get angry, get hungry, stop talking, and start doing.

Third, if and when *de jure* reform occurs, it often bubbles up from below. Long before legislators find the motivation or courage to enact statutes, city councilors and mayors declare states of emergencies—authorizing, for instance, syringe exchanges to combat HIV/AIDS.[235] Local police and prosecutors exercise equitable discretion to look the other way when grassroots activists disobey criminal laws against the possession of naloxone.[236] City officials use local initiatives to push law enforcement to deprioritize the criminal possession of small amounts of marijuana.[237] And the public pass popular resolutions and referenda.[238] Eventually, states may follow suit—but only after witnessing what has worked locally.

Fourth, all the while, the federal structure stays largely intact. Its orientation remains prohibition first. At best, federal officials may tolerate local experimentation. But the federal law remains criminal law—the Controlled

[233] Dorf & Sabel, *supra* note 209, at 841–43; Heller, *supra* note 197; Kirchner, *supra* note 208.

[234] Joseph William Singer, *The Player and the Cards: Nihilism and Legal Theory*, 94 YALE L.J. 1, 55 (1984).

[235] *See* Burris, *supra* note 185, at 1164 (discussing approaches taken by Philadelphia, Cleveland, Los Angeles, and San Francisco).

[236] *See id.* at 1162, 1164 (observing that many early-adopter jurisdictions did not implement syringe exchange programs through legally authorized means but through community "acquiescence" and "negotiation" with law enforcement). *See generally* Ricky N. Bluthenthal et al., *Impact of Law Enforcement on Syringe Exchange Programs: A Look at Oakland and San Francisco*, 18 MED. ANTHROPOLOGY 61 (1997) (comparing disparities in law enforcement against syringe exchange programs across neighboring municipalities during the 1990s). On equitable discretion, see generally Josh Bowers, *supra* note 11, at 1655.

[237] *See Lowest Law Enforcement Priority Jurisdictions*, MARIJUANA POL'Y PROJECT, https://www.mpp.org/issues/criminal-justice/lowest-law-enforcement-priority-juris dictions/ [https://perma.cc/NU3G-748Q]; *see also* Amanda Ross & Anne Walker, *The Impact of Low-Priority Laws on Criminal Activity: Evidence from California*, 35 CONTEMP. ECON. POL'Y 239, 241 (2016).

[238] Ross & Walker, *supra* note 237, at 242 tbl.1 and accompanying text; *see, e.g.*, Curtis J. VanderWaal et al., *State Drug Policy Reform Movement: The Use of Ballot Initiatives and Legislation to Promote Diversion to Drug Treatment*, 36 J. DRUG ISSUES 619, 624–26 (2006).

Substances Act and other punitive statutes like it.[239] Even today, federal support for syringe exchanges is largely passive[240]—a marked improvement to be sure, but still nothing close to the full-throated support that this proven intervention deserves. Likewise, the federal government continues to oppose medical cannabis.[241] And, perhaps more importantly, it continues to stifle medical cannabis research[242] (thereby keeping technically true the hollow claim that the substance has no *proven* medical benefits).[243]

It is against this backdrop—and within this framework—that we should consider addiction maintenance. Addiction maintenance is more than a theoretical possibility; it is an historical and international reality.[244] But, as a domestic practice, it remains far off. How far off is unclear. By nature, subterranean grassroots enterprises are hard to track. It could well be that an American addiction maintenance clinic is operating illegally already—either with a wink and nod from local officials, or completely underground. We hope that there is. The lives of heroin dependent persons rely upon access to pharmaceutical-grade heroin, instead of toxic street-corner junk.

More to the point, a precursor to the addiction maintenance clinic has already begun to find traction—the supervised injection facility, which does not supply drugs but provides a space for relatively safe consumption.[245] Here, the familiar dynamics are playing out yet again. International experimentation

[239] *See, e.g.*, *The Controlled Substances Act*, U.S. DRUG ENFORCEMENT ADMIN., https://www.dea.gov/controlled-substances-act [https://perma.cc/9D6D-GHVB].

[240] Victoria Knight, *Needle Exchanges Find New Champions Among Republicans*, KAISER HEALTH NEWS (May 9, 2019), https://khn.org/news/needle-exchanges-find-new-champions-among-republicans/ [https://perma.cc/5CYD-K477] (noting the belated and piecemeal but evolving support for syringe exchange programs by Congress and various Republican state legislatures).

[241] Grinspoon, *supra* note 196.

[242] JOHN HUDAK & GRACE WALLACK, ENDING THE U.S. GOVERNMENT'S WAR ON MEDICAL MARIJUANA RESEARCH 1 (2015), https://www.brookings.edu/wp-content/uploads/2016/06/Ending-the-US-governments-war-on-medical-marijuana-research.pdf [https://perma.cc/XLK2-JHZ3].

[243] *See* Alex Halperin, *Most in US Think Cannabis Has Health Benefits, Despite Lack of Data - Study*, GUARDIAN (July 23, 2018, 5:00 PM), https://www.theguardian.com/society/2018/jul/23/cannabis-health-benefits-american-attitudes-study [https://perma.cc/ZW7A-FSHF] ("According to the US Drug Enforcement Administration, the agency responsible for drug law enforcement, marijuana is a schedule I drug, meaning that it has serious risks and no medical benefits.").

[244] *See* DRUG COURTS ARE NOT THE ANSWER, *supra* note 201, at 16 ("Drug court adaptations in Canada, Australia, and the United Kingdom have expanded measures of success to include decreased drug use and crime, while broadly allowing opioid-maintenance therapy (such as methadone) and, in some circumstances, tolerating cannabis use.").

[245] Janet Burns, *Opioid Activists Are Going Rogue to Prove That Safe Injection Sites Save Lives*, FORBES (Aug. 10, 2017, 2:51 PM), https://www.forbes.com/sites/janetwburns/2017/08/10/opioid-experts-are-going-rogue-to-prove-that-safe-injection-sites-save-lives/ [https://perma.cc/RK95-9MTC].

sparked grassroots curiosity.[246] Grassroots curiosity fed grassroots activism.[247] For some time, it has been an open secret that at least one unsanctioned supervised injection facility has operated within the United States.[248] And activists have lobbied to bring underground safe sites to the surface.[249] Even the American Medical Association has come aboard, declaring support for the model.[250] Likewise, the idea has spread to progressive prosecutors and police commissioners.[251] Just this past year, public health advocates in Philadelphia, with the support of city leaders, formed a nonprofit called Safehouse to open the first aboveground supervised injection facility in the country.[252] Predictably, state officials have opposed the effort with claims that it cannot be done under federal law (though Pennsylvania's Governor has signaled he may keep his hands off of the effort).[253] And federal officials have responded predictably, flexing drug war muscles with obnoxious threats to enforce the so-called crackhouse law against any safe site, should one try to open aboveground.[254] But where there's a will, there's a way—if not in Philadelphia then somewhere else, sometime soon.[255]

[246] *See id.*

[247] *See id.*

[248] *See id.* (describing an unauthorized safe injection site operating in the United States).

[249] *See generally* German Lopez, *Cities Are Considering Safe Injection Sites. A Federal Judge Just Said They're Legal.*, VOX, https://www.vox.com/science-and-health/2018/1/25/16928144/safe-injection-sites-heroin-opioid-epidemic [https://perma.cc/7U6N-C8E3] (last updated Oct. 2, 2019) (discussing advocates' reasons for wanting to open state-approved safe injection sites).

[250] Martha Bebinger, *AMA Endorses Trying Supervised Injection Facilities*, WBUR, https://www.wbur.org/commonhealth/2017/06/16/ama-supervised-injection-facilities-opioids [https://perma.cc/WNZ3-NE2Z] (last updated June 16, 2017, 7:10 AM).

[251] Cherri Gregg, *Krasner: Philly DA's Office Won't Prosecute Those Using Safe Injection Sites*, CBS PHILLY (Feb. 14, 2018, 12:58 PM), https://philadelphia.cbslocal.com/2018/02/14/larry-krasner-safe-injection-sites/ [https://perma.cc/C5BE-J65K]; Joyce Chen, *Philadelphia Wants to Be First U.S. City to Open Safe Injection Sites*, ROLLING STONE (Jan. 24, 2018, 6:07 PM), https://www.rollingstone.com/culture/culture-news/philadelphia-wants-to-be-first-u-s-city-to-open-safe-injection-sites-129463/ [https://perma.cc/EVG5-22J5] (quoting Philadelphia Police Commissioner Richard Ross, who is "keep[ing] an open mind" about safe injection sites).

[252] Bobby Allyn, *As Philly Moves Closer to Supervised Injection Site, Gov. Wolf Remains Opposed*, WHYY (Oct. 8, 2018), https://whyy.org/articles/as-philly-moves-closer-to-supervised-injection-site-gov-wolf-remains-opposed/ [https://perma.cc/839B-GY3B].

[253] *See id.*

[254] *Id.*

[255] Other reform-minded enclaves, like Ithaca, New York, are also toying with the idea. *See, e.g.*, Lisa W. Foderaro, *Ithaca's Anti-Heroin Plan: Open a Site to Shoot Heroin*, N.Y. TIMES (Mar. 22, 2016), https://www.nytimes.com/2016/03/23/nyregion/fighting-heroin-ithaca-looks-to-injection-centers.html [https://perma.cc/2FDP-MY6L].

This is what happened with syringe exchanges and medical cannabis. More to the point, this is what happened in Vancouver.[256] An underground effort by street activists eventually produced a legally authorized supervised injection facility.[257] And that facility, in turn, helped produce an aboveground addiction maintenance clinic—a site where individuals now go to get their fix without needlessly jeopardizing their lives and liberty or, for that matter, public safety and order.[258]

VII. CONCLUSION

Drugs grow organically in our soil.[259] We produce them purposefully in our labs.[260] We take them for pleasure,[261] to alleviate pain,[262] and to feel "normal."[263] We use them to treat our depression,[264] our hyperactivity, our attention deficit disorders,[265] our sexual dysfunction,[266] and on and on. We take them to forget, and we take them to remember. We use them responsibly, and we abuse them to no good end.[267] Recreational drugs are commonly criticized

[256] *See, e.g.*, Lisa W. Foderaro, *Ithaca's Anti-Heroin Plan: Open a Site to Shoot Heroin*, N.Y. TIMES (Mar. 22, 2016), https://www.nytimes.com/2016/03/23/nyregion/fighting-heroin-ithaca-looks-to-injection-centers.html [https://perma.cc/2FDP-MY6L].

[257] *See* Elana Gordon, *What's the Evidence That Supervised Drug Injection Sites Save Lives?*, NPR (Sept. 7, 2018, 2:40 PM), https://www.npr.org/sections/health-shots/2018/09/07/645609248/whats-the-evidence-that-supervised-drug-injection-sites-save-lives [https://perma.cc/F3TB-JHUU].

[258] Lopez, *supra* note 76 (discussing Vancouver's addiction maintenance clinic, Crosstown Clinic); Aleccia, *supra* note 70 (discussing Vancouver's supervised injection facility, Insite).

[259] Therese O'Neill, *8 Drugs That Exist in Nature*, THE WEEK (May 29, 2013), https://theweek.com/articles/464010/8-drugs-that-exist-nature [https://perma.cc/7U6K-FPJ2].

[260] *Id.*

[261] *Drug Misuse and Addiction*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction [https://perma.cc/HUB9-4Z47] (last updated July 2018).

[262] *Pain Relievers*, MEDLINE PLUS (June 12, 2019), https://medlineplus.gov/painrelievers.html [https://perma.cc/E9ED-FCFA] (discussing over-the-counter medication to relieve pain).

[263] *Drug Misuse and Addiction*, *supra* note 261.

[264] *See, e.g.*, *Sertraline (Zoloft)*, NAT'L ALLIANCE ON MENTAL ILLNESS (Dec. 2018), https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/sertraline-(Zoloft) [https://perma.cc/QU8X-SXWH].

[265] Lynn Marks, *ADHD Treatment*, EVERYDAY HEALTH, https://www.everydayhealth.com/adhd/guide/treatment/ [https://perma.cc/SM8T-VVS6] (last updated Apr. 23, 2018) (listing the medications available for attention deficit hyperactivity disorder).

[266] *See, e.g.*, *How Does Viagra Work*, VIAGRA (Sept. 2018), https://www.viagra.com/learning/what-is-ed [https://perma.cc/S2AU-C7T9].

[267] *Drug Misuse and Addiction*, *supra* note 261.

for—among other things—producing a false sense of reality.[268] But, as sober-minded citizens, we have lost sight of our own reality. Drugs surround us. The drug-free society is a pipe dream. The goal is not only wrongheaded and hopeless, but also pernicious. To preach drug eradication is to preach drug prohibition. And the logic of prohibition is grounded, necessarily, in the ideology of punishment and acts of state-sponsored violence.

If, instead, we were to acknowledge that drugs are an often (but not always) unfortunate fact of life (just like sugar, red meat, pollution, automobile accidents, and the flu) we might come to regard drug misuse, abuse, dependence, and addiction for what they are—questions of health, not morality; social policy, not penology. The measure of success would not turn on our proximity to a drug-free America. The measure of success would be whether we have minimized drug-related deaths, disease, crime, and suffering; whether we have improved health and welfare; whether we have preserved and expanded autonomy and dignity; whether we have generated and subscribed to sound science directed toward morally appropriate ends; and, most importantly, whether we have cared compassionately for each other as equal members of a social collective.

There is a silver lining to our current moment. The opioid crisis has awoken a previously indifferent (white) America to the evils of its policies.[269] We are hopeful, but not overly so, that this awakening may translate to meaningful changes all the way up to the federal level.[270] But the recent crackdowns against doctors inspire little confidence. We expect that there will be more street-level activism and local initiatives (and also that these steps will prove politically popular). But, ultimately, the moves we make will be too few. The logic of

[268] *What You Need to Know About Drugs*, KIDSHEALTH (Apr. 2018), https://kidshealth.org/en/kids/know-drugs.html [https://perma.cc/SRL9-77VG] ("A drug might—temporarily—make someone who is sad or upset feel better or forget about problems. But this escape only lasts until the drug wears off. Drugs don't solve problems . . . using drugs often causes other problems on top of the problems the person had in the first place.").

[269] *See generally* Bell, *supra* note 14 (describing "interest convergence" and white America).

[270] For the reasons discussed in Part V, we are doubtful that federal authorities can or will genuinely reorient away from prohibition, even when it comes to opioids. Still, we are encouraged that the United States Senate—by a remarkable vote of ninety-nine to one—recently passed sweeping legislation that might make it easier for doctors to prescribe suboxone and other forms of medication-assisted treatments for addiction. Coby Itkowitz, *Senate Passes Sweeping Opioids Package*, WASH. POST (Sept. 17, 2018), https://www.washingtonpost.com/politics/2018/09/17/senate-set-pass-sweeping-opioids-package/?utm_term=.3f9802c2ea72 [https://perma.cc/AMK9-XDU7]. Suboxone is a brand name for buprenorphine. *See* Michele Brooks, *Brooks' Bill to Curb Suboxone Abuse Passes Senate* (June 28, 2019), https://www.senatorbrooks.com/2019/06/28/brooks-bill-to-curb-suboxone-abuse-passes-senate/ [https://perma.cc/WD8W-GCDP]. Again, "interest convergence" has a way of making the seemingly impossible suddenly possible, even if not for entirely admirable reasons. *See generally* Bell, *supra* note 14 and accompanying text (discussing "interest convergence" theory of race and politics).

prohibition and the ideology of punishment will continue to predominate. Such is the power of the leviathan—of drug war culture, politics, and dollars. The machinery of penal justice will continue to churn. That's what machines tend to do.[271] Still, we offer this pragmatic six-point plan for addressing our current opioid crisis (pragmatic, but not ideal, because—though it would reduce opioid-related death and suffering—it would not dismantle the architecture and instruments of punitive prohibition).

911 Amnesty from arrest for all drug offenses for all individuals who contact authorities to report overdoses or persons in need of aid.[272]

Naloxone available without prescription or cost at pharmacies, fire stations, public libraries, police stations, hospitals, jails and prisons, and supervised injection facilities.[273]

Pill and Powder Testing available without cost to assess drug purity and to detect the presence of fentanyl and other dangerous compounds, as a means to enable drug users to make informed choices about whether and how to use substances.[274]

Medication-Assisted Treatment available with prescription but without cost, within and beyond clinical settings, for all individuals who require it, inmates included, without forced detoxification after fixed time periods.[275]

[271] *See generally* STEPHANOS BIBAS, THE MACHINERY OF CRIMINAL JUSTICE (Oxford U. Press 2012) (comparing the machinery of criminal justice to an assembly line).

[272] *See Good Samaritan Fatal Overdose Prevention Laws*, DRUG POL'Y ALLIANCE, http://www.drugpolicy.org/issues/good-samaritan-fatal-overdose-prevention-laws [https://perma.cc/UJW2-25H9].

[273] *See* Matthew R. Jordan & Daphne Morrisonponce, *Naxolone*, NAT'L CTR. FOR BIOTECH. INFO. (Feb. 19, 2019), https://www.ncbi.nlm.nih.gov/books/NBK441910/ [https://perma.cc/NGM9-BBPY] ("There is no question that naloxone is of great benefit in preventing the accidental overdose from opioids . . . .").

[274] *See generally* Tibor Brunt, *Drug Checking as a Harm Reduction Tool for Recreational Drug Users: Opportunities and Challenges*, EUROPEAN MONITORING CTR. FOR DRUGS & DRUG ADDICTION (2017), http://www.emcdda.europa.eu/system/files/attachments/6339/EuropeanResponsesGuide2017_BackgroundPaper-Drug-checking-harm-reduction_0.pdf [https://perma.cc/926F-ZCY9] (discussing the history and expansion and pros and cons of drug testing procedures in Europe); Tibor M. Brunt et al., *Drug Testing in Europe: Monitoring Results of the Trans European Drug Information (TEDI) Project*, DRUG TESTING & ANALYSIS (2016), https://energycontrol-international.org/wp-content/uploads/2016/04/Drug-Testing-in-Europe-Monitoring-Results.pdf [https://perma.cc/UM7P-GWPR] (presenting data on drug testing systems in Spain, Switzerland, Belgium, Austria, Portugal, and the Netherlands).

[275] *See generally* Kate Sheridan, *How Effective Is Medication-Assisted Treatment for Addiction? Here's the Science*, STATNEWS (May 15, 2017), https://www.statnews.com/2017/05/15/medication-assisted-treatment-what-we-know/ [https://perma.cc/VHF6-8G6P] (describing various studies on the effectiveness of medication-assisted treatment).

Supervised Injection Facilities/Drug Consumption Rooms and Syringe Exchanges available without cost and in areas of concentrated injection drug use.[276]

Physician-Supervised Addiction Maintenance Programs available with prescription but without cost for individuals for whom other forms of medication-assisted therapy have failed.[277]

The empirical and anecdotal evidence is persuasive that these interventions will save lives, alleviate suffering, and lessen drug-related crime.

The virtue of the criminal law is that it is relatively certain.[278] The vice is that (at least when it comes to the drug war) the criminal law is almost certainly wrong. We must acknowledge and abandon our addiction to punishment and broaden our legal horizons to adopt measures proven to reduce the use, misuse, and abuse of drugs in an effort to avoid harms related both to drug use and the drug war. People are dying at record numbers.[279] History will judge harshly our inaction.

[276] *See generally Safe Injection Sites: Are They Helping or Hurting*, NOVA RECOVERY CTR. (Nov. 14, 2018), https://novarecoverycenter.com/addiction/safe-injection-sites/ [https://perma.cc/7W3U-VKG8] (summarizing research on safe injection sites).

[277] *See generally* Gavin Bart, *Maintenance Medication for Opiate Addiction: The Foundation of Recovery*, 31 J. ADDICTIVE DISEASES 207 (2012) (summarizing effectiveness of medication-assisted treatments).

[278] Stephen R. Perry, *Judicial Obligation, Precedent and the Common Law*, 7 OXFORD J. LEGAL STUD. 215, 256 (1987) (discussing the "especial need for certainty" in criminal law).

[279] *See, e.g.*, Evan MacDonald, *Heroin and Fentanyl Killed More People in Cuyahoga County in 2016 Than Homicides, Suicides and Car Crashes*, CLEVELAND.COM (May 2017), https://www.cleveland.com/metro/2017/05/heroin_and_fentanyl_killed_mor.html [https://perma.cc/BCP4-AUUV].